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A Discourse Analysis of Transsexuality through Three Fields: Expert Knowledges in Legal. Medical and News Texts

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A Discourse Analysis of Transsexuality through Three Fields: Expert Knowledges in Legal, Medical and News Texts

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Abstract

Employing a Foucauldian discourse analysis, this thesis examines knowledge produced about transsexuality and sex reassignment surgery (SRS) through the fields of medical, legal and news texts. I explore key shifts in Western feminist, queer and trans approaches to sex/gender and the *Diagnostic and Statistical Manual of Mental Disorders'* pathologization of gender-variance in the Gender Identity Disorder diagnosis. I also undertake a case study of trans marriages prior to Bill C-38, and the Ontario *Vital Statistics Act*'s reliance on medical proof in change of sex designation requests. Finally, I analyze seventy-seven texts from *The Globe and Mail*, *The Toronto Star*, *National Post* and *Toronto Sun* spanning the 11-years (1998-2008) during which SRS was not funded in Ontario. The news coverage employs expert knowledge in legitimizing and de-legitimizing transsexuality and SRS. Overall, all three fields rely on cisnormative patterns of knowledge production and reflect the privilege granted to cissexuals in Canadian society.

Key Words: Discourse, Transsexuality, Cisnormativity, Cissexual Privilege, Sex Reassignment Surgery, Gender Identity Disorder, Feminism, OHIP Delisting/Relisting, Public Funding for SRS, Ontario, Newspapers, Trans PULSE Project

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Abbreviations

APA	American Psychiatric Association
BCHRC	British Columbia Human Rights Commission
CAMH	Centre for Addiction and Mental Health
CBCA	Canadian Business Current Affairs
CHA	Canada Health Act
CHRA	Canadian Human Rights Act
CHT	Canada Health Transfer Payment Programme
Clarke	Clarke Institute of Psychiatry
DSM	Diagnostic and Statistical Manual of Mental Disorders
FtM	Female-to-Male Transsexuals
GIC	Gender Identity Clinic [at Clarke/CAMH]
GID	Gender Identity Disorder
GLQ	A Journal of Lesbian and Gay Studies
ICD	WHO's International Classification of Disease
LQBTQ	Lesbian, Gay, Bisexual, Transsexual/gender, Queer
MP	Member of Parliament
MPP	Member of Provincial Parliament
MtF	Male-to-Female Transsexuals
OHIP	Ontario Health Insurance Policy
OHR Code	Ontario Human Rights Code
OHRC	Ontario Human Rights Commission
OHRT	Ontario Human Rights Tribunal
OMA	Ontario Medical Association
OMHLTC	Ontario Ministry of Health and Long-Term Care
PSC	Physician Services Review Committee
SOB-PS	Schedule of Benefits – Physicians Services
SRS	Sex Reassignment Surgery
WHO	World Health Organization
WPATH	World Professional Association for Transgender Health (Formerly the Harry Benjamin International Gender Dysphoria Association, HBIGDA)

Key Terms

Cisnormativity	Those expressions and behaviours that are taken to be natural when accorded to cissexuals, and the belief that trans bodies and identities are unnatural or less authentic.
Cissexual	Individuals who have only experienced their felt gender and physical sex as aligned, and who are not transsexual.
Cis-privilege	Refers to the taken-for-granted ways cissexuals are privileged under cisnormativity.
Gender Dysphoria	Psychiatric term for extreme discontent with the sex one is born.
Hysterectomy	The surgical removal of the uterus.
Intersex	The condition of ambiguous or non-congruent sex features, including those individuals who otherwise deviate from the sexually dimorphic 'norm'; such as having the gonadal tissue of both male and female individuals or external genitalia of one sex and the gonads of another sex.
Mastectomy	The surgical removal of the breasts.
Metoidoioplasty	The creation of a neopenis from the clitoris through the effects of androgen hormone treatment. The enlarged clitoris is released from its position and can serve as a penis. An alternative to phalloplasty.
Orchiectomy	The surgical removal of the testes.
Ovariectomy	The surgical removal of the ovaries.
Phalloplasty	The surgical techniques for penile reconstruction. There does not exist one single ideal surgical technique for phalloplasty, and results may vary.
Transgender	An individual who identifies with or expresses a gender identity that differs from the one that is culturally understood to correspond to their sex as assigned at birth.
Transphobia	The fear, loathing and discriminatory treatment of those individuals whose gender identity or expression (or perceived gender or gender identity) does not match their birth assigned sex.
Transsexual	An individual with an experience of gender incongruence, who identifies with and/or wishes to live as the sex/gender 'opposite' to the one assigned at birth, and who may desire hormone therapy and surgery to obtain the physical characteristics of the 'opposite sex'.
Vaginoplasty	The surgical procedure(s) to create the neovaginal cavity; can involve the amputation of the penis, the creation of the neovaginal cavity, lining of this cavity, the reconstruction of the urethral meatus to control the direction of the urinary stream, and the construction of labia and clitoris.

Introduction

"[M]edical case studies do not simply 'record', but work to 'produce' knowledge" – Sally Hines 2007, 68

On December 1st, 1952, Christine Jorgensen made waves in the Western world when the *New York Daily News* announced her 'sex change', and the front-page story escalated into a 'media frenzy' of international proportions (Meyerowitz 159). Jorgensen, however, was not the first transsexual to garner news attention. Joanne Meyerowitz suggests "stories of 'sex reversals,' 'sex changes,' and 'sexual metamorphoses' had appeared in American newspapers and magazines since the 1930s," and in European accounts starting in the late nineteenth century (159). However, it was the explosion of Jorgensen's high profile transition and the popularization of the term 'transsexual' by Harry Benjamin and David Cauldwell in the late 1940s and 1950s[1], that inspired a Western fascination with tales of individuals crossing established sex/gender boundaries. Sensationalized stories questioning an individual's 'real' sex or gender, tales of betrayal, and medical intervention appear often in a variety of media sources.[2] Julie Hollar's examinations of the major American network and cable news programs in 2007 found that coverage of transgender issues are still "plagued with a narrow uniformity of subjects and a relentless and invasive fixation on anatomy" (n. p.).

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1 Meyerowitz continues, noting that prior to the 1960s and "well before American doctors adopted the term transsexual, the mass media seem to have played a crucial role in disseminating the concept of surgically altered sex" (179).

2 For example, The Jerry Springer Show embodies said narratives, with such episode titles airing in 2009 as: *Oops...I Had Sex with a Tranny!* (Air date: 11/11/2009); *Transsexual Tell-All* (Air date 11/6/2009); *Transsexual Takedown* (Air date 9/18/2009); *Tricked by a Transsexual!* (5/13/2009); and, *Brothers' Transsexual Surprise!* (Air date: 1/21/2009). Other examples include coverage by the *New York Post* (6/13/04, "Tranny RX Sex Scams"), and CNN's Larry King, which aired four shows concerned with gender identity between 2005 and 2007. Canadian examples include CBC's The Fifth Estate feature *Becoming Ayden* (October 13 2004), and The Passionate Eye documentary *The Third Sex*, which focuses on intersexuality (December 31 2009).

What is transsexualism? In this thesis, I define transsexualism as the condition experienced by individuals with a sense of incongruence between their birth-assigned sex and their felt gender. For many scholars and community members, transsexualism can be subsumed under the umbrella term transgender.[3] Transsexuals comprise the most-studied trans community (Lawrence 474), and in the last century a wide variety of discourses have emerged that construct the Western understanding of transsexualism. These discourses are often concerned with the desire for medical intervention in the form of hormone therapy and/or sex reassignment surgery (SRS)[4], which are considered the treatment of choice by many transsexuals and medical personnel (De Cuypere et al. 679). The emphasis placed on trans persons and medical intervention has produced a discourse that is overtly scientific or theoretical in nature. I employ the broader term 'trans' in this thesis in an attempt to include individuals experiencing gender incongruence, regardless if they undertake hormone therapy or employ surgical procedures in order to achieve congruence.

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[3] I must highlight that not all scholars, activists and community members agree upon the inclusion of 'transsexual' under the term 'transgender'. For a discussion of this argument, refer to the works of Viviane Namaste. There is also debate regarding the usage of the term 'transsexual' in referring to individuals who seek – but do not necessary obtain – sex reassignment surgery. For a criticism of this usage, refer to Jon K. Meyer who proposes to retain the term transsexuals only for those individuals who undergo, and complete, 'genital reassignment'. However, Margrit Eichler notes that the process of distinguishing between pre-operative and post-operative transsexuals stresses the surgical aspect of transsexualism over the cultural aspect. This distinction assumes that all transsexuals desire and will attain surgery, emphasizing surgery and a clinical approach to transsexualism (Meyer 527-58; Eichler 281-290). It should also be noted that within the trans community there is disagreement as to the recognition of a transsexual's sex: some transsexuals desire their 'new' sex to be recognized by society and the courts, whereas others – such as Sandy Stone and Kate Bornstein – make arguments for their recognition as *transsexual* women.

[4] I use 'sex reassignment surgery' because it is the phrase used in the Canadian context by the majority of activists, medical and legal personnel. In other Westernized countries - such as Australia - the phrase 'sex affirmation' is used to refer to the "rehabilitative hormone therapy and surgical procedures undertaken to transform the rest of the body to match the sex of the brain, to the fullest extent possible" (Wallbank n. p.).

In academic fields such as the social sciences and humanities, psychology, and law the conceptualization of the relationship between sex and gender continue to be examined in light of trans subjectivities and identities. Such academic works continue to engage with the concept of gender as a system, a way of organizing our lives. Gender permeates our structured world in a variety of ways, influencing legal definitions, medical concepts and childrearing patterns. In contemporary Canadian culture, it is still taken as natural that a male body should only signify a masculine gendered identity, and that a female body only signifies a feminine one. Such truths about gendered expression and behaviour are constituted in contemporary discourses of gender and problematized by trans identity. This thesis endeavours to examine three separate but intersecting fields of knowledge production about transsexuality and sex reassignment surgery through a Foucauldian discourse analysis of legal, medical and news texts.

As a system of representation, discourses go beyond simply describing our social world; as a social practice, they *reflect* and *construct* the social world. Discourses, therefore, categorize and give meaning to objects and phenomena. In *The Archaeology of Knowledge,* Michel Foucault writes that discourse refers to "a group of sequences of signs, in so far as they are statements, that is, in so far as they can be assigned particular modalities of existence" (2005, 121).[5] Foucault's conception of discourse can be thought of as a field in which possible statements about a given topic, area or object can be produced and become known. Ian Parker provides a working definition of a discourse as "*a system of statements which constructs an object*" (emphasis in original, 252). In

[5] R. Keith Sawyer (2002) argues that Anglo-speaking scholars increasingly began to attribute the broad usage of the concept 'discourse' to Foucault, when it should be attributed to British cultural studies collectively, to Lacan, or to the French Marxist discourse analysts working in the 1960s and 1970s (depending on the specific theoretical usage and intended connotations).

particular, Foucault's work highlights the role of discourse as producer – and constrainer – of knowledge (S. Hall 72). For Foucault, "Knowledge is that of which one can speak in a discursive practice, and which is specified by that fact" (2005, 201). Foucault continues this thought to conclude,

> … knowledge is also the space in which the subject may take up a position and speak of the objects with which he [sic] deals in his discourse…; knowledge is also the field of coordination and subordination of statements in which concepts appear, and are defined, applied and transformed…; lastly, knowledge is defined by the possibilities of use and appropriation offered by discourse… (2005, 201).

For example, Foucault's examination of 'madness' notes that "mental illness was constituted by all that was said in all the statements that named it, divided it up, described it, explained it, traced its developments, indicated its various correlations, judged it, and possibly gave it speech by articulating, in its name, discourse that were to be taken as its own" (2005, 35). A similar argument can be put forth for transsexuality. As a category, knowledge about transsexuality is constituted through all the various discourses that articulate it, including psychoanalytical theory, and endocrinological and surgical practices.

Using a Foucauldian notion of discourse, it is my aim here to analyze texts about transsexuality and sex reassignment surgery, and explore how they evoke and re-produce particular meanings.[6] I make use of the term 'texts' here to refer to groups of statements, written or spoken, which also find meaning in social practices and conduct. Discourses are more than systems of representation; they are discursive practices, the basis of actions

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[6] This thesis was written with Jacob Hale's "Suggested Rules for Non-Transsexuals Writing about Transsexuals, Transsexuality, Transsexualism, or Trans" (1997) in mind. I am aware that my selection of texts is a social process and reflective of the production system of knowledge and discourses on gendered and sexed objects. While this project does not aim to speak of the lived experiences of transsexuals, it is my hope to move away from the history of problematic scholarship that reduces trans subjects to the status of objects by critically engaging with the selected discourses that heavily 'produce' transsexuality in Ontario.

that shape the world and what we can accomplish within it. Discursive practices are characterized by the "delimitation of a field of objects, the definition of a legitimate perspective for the agent of knowledge, and the fixing of norms for the elaboration of concepts and theories" (Foucault 1977, 199). As Parker notes, for Foucault, "discourses and practices should be treated as if they were the same thing, and it is true both that material practices are always invested with meaning (they have the status of a text) and that speaking or writing is a 'practice'" (258). In other words, the various discourses that I examine within this thesis – feminist, legal, medical and news media – are implicated within the structures of their institutions. The examined discourses exist in a variety of texts and practices: in journals and books, in policies and legislations, in editorial meetings and printing shops, in court and professional council decisions, in women's groups, in educational institutions, and in meetings with other members in the field (feminists, lawyers, doctors or journalists). Hence, I approach trans subjectivity with the understanding that institutions and discourses are interconnected.

Although discourses work in texts, their meanings "go beyond individual intentions" (Parker 253). Individual subjects can produce particular texts – as my examination of Margaret Wente's *Globe and Mail* columns in Chapter Three indicates – but these texts continue to operate within the limits of the discursive formation[7] of a particular period and culture. A Foucauldian understanding of discourse maintains that discourses are not static; instead, they are historically located and change and develop

[7] Foucault discusses discursive formations in Part II of *The Archaeology of Knowledge*. We may think of discursive formations as a system of statements or the historically situated fields of knowledge. Foucault writes that we can say we are dealing with discursive formations when "one can describe, between a number of statements, such a system of dispersion, whenever, between objects, types of statement, concepts, or thematic choices, one can define a regularity (an order, correlations, positions and functioning, transformations)" (2005, 41).

based on their connections to other discourses.

Most importantly, discourses determine who can speak, when they can speak, and with how much authority. According to Foucault (1990), knowledge and accompanying statements are the result of the effect of power. In particular, Foucault's work examines how power functions, how it is exerted and resisted in society through "institutions, economic and social processes, behavioural patterns, systems of norms, techniques, types of classification, [and] modes of characterization" (Foucault 2005, 49). Foucault approaches power not from a traditional top-down manner – exemplified through the rule of a sovereign – but, rather, as more than merely repressive. For Foucault, power is productive, permeating all levels of society and constituting itself through knowledge (Cheek 1143; S. Hall 77). Power enables particular knowledges to be produced or constrained, and creates new discourses and discursive regimes; understood otherwise, power can shape what a society "knows" as truth. Foucault suggests that power is directly linked to production: "it produces reality; it produces domains of objects and rituals of truth" (1995, 194). Power perpetuates itself through knowledge, which is imposed on objects through discourse to produce objectivity, or an objective reality. Foucault proposes that the terms power and knowledge be joined as one (power-knowledge), as they imply one another: "There is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time power relations" (Foucault 1995, 27).

In *The Archaeology of Knowledge*, Foucault argues that those people who are deemed experts in society have the ability to speak truth. Such authorities come from similar institutions – e.g. the government, legal system, and the academe – and maintain

their authority within these systems. As such, experts tend to become subsumed under these dominant discursive formations. Similarly, some groups benefit from a particular discourse and may wish to deny that this specific system of meaning *is* a discourse, while others are simultaneously oppressed by the same system of categorizing reality. For example, discourses that deny the validity of transsexuality – of a felt experience of incongruence between one's birth sex and self-identified gender – oppress those persons who experience the world and their place within it as such. This approach to the sex/gender relationship benefits cisnormativity which can be understood as those expressions and behaviours that are taken to be natural when accorded to cis-people (non-trans individuals) and the belief that trans bodies and identities are unnatural or less authentic. Discourses that diminish the phenomenon of transsexuality are also reflective of existing localized power relations in the province of Ontario. Using discourse analysis, I take into consideration both the objects and the subjects that are referred to in the texts, how they are described and what they can say within the discourse (Parker 254).

In its earliest manifestations, my project was inspired by the changes made in the coverage delisting (1998) and relisting (2008) of sex reassignment surgery under the Ontario Health Insurance Policy (OHIP) and was confined to examining news texts alone. As the project progressed, however, it became apparent to me that mainstream news texts constitute only one discourse – albeit a decidedly public one – in which knowledge about transsexuality is circulated and where transsexuality is produced as an object. This realization was attributed to the Foucauldian notion that knowledge about transsexuality exists meaningfully within discursive formations about a given topic. I discovered that transsexuality is also constituted in legal and medical discourses. That is

not to deny the existence of transsexuality outside such fields, but to argue that transsexuality takes on meaning and becomes an object of knowledge within discourse, and transforms into truth when applied in the real world. Stuart Hall writes, "Foucault argues that since we can only have knowledge of things if they have a meaning, it is discourse – not the things-in-themselves – which produces knowledge" (73). Therefore, the knowledge produced in medical, legal and news texts about transsexuality manifest as truths in social structures, and influence institutional and policy decisions that affect trans persons. My examination of these discourses about transsexuality was the guided by the following research questions:

1. Who and what are viewed as 'normal' and 'natural' within the texts?
2. What narratives are presented as legitimate/illegitimate within the texts?
3. In what ways do expert knowledges appear within the discourses, if at all?
4. Do the texts contain references to broader societal practices that are oppressive towards transsexual identities?
5. In relation to the news texts, how are the changes to the OHIP policy justified by the Ontario Ministry of Health and Long-Term Care?
6. Is sex reassignment surgery presented as cosmetic/elective or medically necessary surgery within the texts?

I also draw on Julia Serano's use of cissexual to refer to "people who are not transsexual and who have only ever experienced their subconscious and physical sexes as being aligned" (12), and adopt this term to highlight the naturalization that is traditionally accorded to those bodies.[8]

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[8] The Oxford English Dictionary defines the prefix "cis", from the original Latin, to denote "on this side of" and "trans-" as a "prefix denoting through, across, or beyond" (OED online 2008). It should be noted that cis can be conceptualized as a description of the way that one is perceived by others, rather than actual differences between cissexuals and trans- persons. Just as it is important to remember that not all trans persons experience the world in the same way, I also do not perceive all cissexuals to be homogenous nor for cissexuals to escape other forms of prejudice such as racism, classism, sexism, homophobia or (dis)ableism.

In Chapter One, I begin by outlining some of the recent historical shifts in Western[9] feminist theoretical understandings of the relationship between sex and gender, and the condition of transsexuality. I highlight the shift from a traditional conception of sex and gender as naturally coupled, to more recent discourses that challenge the claim that gender identity and biological sex are inherently linked phenomena. I begin with an examination of Simone de Beauvoir's 1953 seminal work, *The Second Sex*. From there, I move forward and engage with the works of Judith Butler, Toril Moi and Iris Marion Young. I also examine the arguments of Janice G. Raymond, Marcia Yudkin, Bernice Hausman and Margrit Eichler. As feminists who view transsexuality and sex reassignment surgery as problematic, their works complicate the discourse on transsexuality. Notably, these authors approach transsexuality as pathology, and argue that transsexuals are victims of an intolerant culture and a threat to "women". I suggest that the condition of transsexuality and transsexuals have been represented in a variety of ways by feminist and queer studies scholars: as pathologized subjects; as victims or "dupes" of a rigid, binary gender system; as co-conspirators in that system through stereotypical performances of woman- and man-hood; as gender outlaws; and as revolutionaries. Overall, this chapter builds a theoretical base for my understanding of sex, gender and the discourse of transsexuality.

In Chapter Two, I explore the structure of medico-legal apparatuses and their reliance on cisnormative patterns of knowledge production. I investigate the role of 'expert knowledge' as professional expertise that orders our social world and organizes

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[9] An inherent limitation in my work arises from my focus on Western thought, the majority of which is written by English speaking theorists and activists. This focus on Western thought is undertaken, in part, due to linguistic limitations and because American and European theoretical traditions have greatly influenced the current hegemonic Canadian conception of gender.

the social environment in which we live. By considering the interconnected nature of legal and medical discourses as systems of expert knowledge, I highlight our reliance on experts as the definers of truth in mediating our understanding of sex reassignment surgery and transsexuality. Overall, this chapter argues that the American Psychiatric Association's Gender Identity Disorder (GID) diagnosis outlined in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) is essential to a legal understanding of transsexuality in Ontario. I begin the chapter with a historical case study of the importance of determining sex designation for marriages in Ontario prior to the passing of the 2005 federal Bill C-38, the Civil Marriage Act. I do so in order to call attention to the extent of (cis)normative understandings of sex and gender within legal discourses that have recently been questioned by non-cissexuals and allies. My main argument for this chapter remains that trans individuals wishing to have their felt sex/gender acknowledged by the Ontario government must submit themselves to a medicalized system by first receiving medical acknowledgment of their gender dysphoria through the diagnosis of GID. Trans individuals must then receive approval for sex reassignment surgery by the Centre for Addiction and Mental Health (CAMH), and finally submit proof of transition to the Registrar General before they can attain recognition. Under Ontario's *Vital Statistics Act* (R.S.O. 1990, c. V. 4, s. 36), requests for alterations to sex designations on government documents require proof by means of certification by two medical practitioners testifying to the results of the surgery. This burden of proof reflects the guarded systems of expertise that exert influence over trans lives.

In this chapter, I also examine the problematic components of the GID diagnostic criteria and present the results from Phase I of the Trans PULSE Project, a

comprehensive community-based research project aimed at documenting the lived experiences of trans people in Ontario. The Trans PULSE Project's Phase I's results, published in the September/October 2009 issue of the *Journal of the Association of Nurses in AIDS Care*, provides a framework for theorization about the social determinants of health care, social exclusion and sites of erasure. The Trans PULSE Project underlines emerging new research initiatives that engage consciously with the concerns of the trans community at every level of research. The members of the Trans PULSE research project note the real lack of availability and accessibility of information on issues of concern to the trans community. As such, they aim to produce the types of information "needed by individuals to make informed decisions; information needed by care providers to provide the best care, and; information needed by advocates and policy makers to make decisions that are informed by solid evidence" (Bauer et al. 2007, 3). This form of knowledge production connotes a shift in the discourse of transsexuality.

Chapter Three includes my discourse analysis of four major Canadian news producers based in Ontario: *The Globe and Mail*, *The Toronto Star*, *National Post* and *Toronto Sun*. Before presenting the results of my findings, I situate my data analysis by providing some background on the provincial system of health care, the delisting and relisting of sex reassignment surgery under the SOB-PS, and the main challenge to the delisting in *Hogan v. Ontario* (2006). Keeping in line with the argument that news producers shape and define truth, I analyze a total of 77 articles along tonal and linguistic dimensions. I provide in-depth analysis of hard news texts, opinion columns and letters to the editor. I note the role of experts from the medical and legal communities and the Ministry of Health and Long Term Care in defining transsexuality and sex reassignment

surgery for the general reading public. This discourse analysis supports the argument that transsexuality remains marginalized in a cisnormative culture. This marginalization is due, in part, to the incomprehensibility or misunderstanding by the general population of the condition of transsexuality as against "the norm". This misunderstanding is most notable in negative responses to the relisting of sex reassignment surgery, and the positing of SRS against other delisted services, and was best observed in the opinion columns and the letters to the editor.

Overall, this research project makes contributions to the interdisciplinary fields of trans studies and media studies. As a project solidly concentrating on Canadian narratives, I address gaps in the study of discourses of Canadian transsexuality by examining the discursive practices that position trans Canadians as "others" due to their non-conformity to traditional gender identities. Individuals who transgress accepted social conventions may struggle in having their subject positions acknowledged as legitimate and not pathological or abnormal. This struggle can be dangerous and disruptive. It can also be one way through which change can be achieved in discourse and social practice by questioning established norms. I believe that an examination of trans issues not only allows us to work towards social justice, but also allows us to highlight discursive assumptions about normative gender systems, and their production, maintenance and reproduction. In total, the various discursive fields and texts that I explore function as important sites for the positioning and problematization of trans issues.

1. Positioning Transsexuality in Feminist and Queer Discourses

"Gender is a key organizing concept of institutions and practices in culture and society"
– Diane Richardson 2008, 3

"[T]he denaturalization of sex, in its multiple senses, does not imply a liberation from hegemonic constraints..." – Judith Butler 1993, 133

Gender variance that challenges social norms is a significantly misunderstood facet of human phenomenon. Discomfort with one's gender 'performance' and/or bodily manifestations are sensationalized within the media[10], and remain a contested terrain among mental health professions.[11] This chapter outlines significant shifts in feminist discussions of the relationship between sex and gender, and the condition of transsexuality. I begin with an examination of Simone de Beauvoir's 1953 work, *The Second Sex*, and move forward to the present, engaging with feminists and queer theorist writings on transsexuality. In particular, I engage primarily with the works of Judith Butler, Toril Moi and Iris Marion Young. I also examine the arguments of Janice G. Raymond, Marcia Yudkin, Bernice Hausman and Margrit Eichler, whose feminist writings view transsexuality and sex reassignment surgery as problematic. Notably, these authors approach transsexuality as pathology, and argue that transsexuals are victims of an intolerant culture and a threat to "women".

The formation of our Western social world through a dichotomous system based on two – and only two – sexes has the tendency to constrain and police sexual subjects who deviate from the hegemonic norm(s). This policing may take the form of

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10 Refer to note 2 for an expansion on this point.

11 Conflicting scientific and social science theories view the 'cause' of gender dysphoria to be acquired biologically (postnatal or parental) or the result of an environmental or social factor, particularly those occurring in early childhood. Tugnet et al. note that early psychodynamic literature considered the familial relationship of the boy (sic) with his mother as the cause of GID. Other theories considered surges of female hormones during key stages of development of the fetus to cause GID (Tugnet et al., 638). [Both examples here emphasize potential causes for MtF transsexuality].

pathologizing transgender subjects by medical and surgical institutions, acts of violence against the deviant subject, or legal troubles stemming from identification documents that differ from an individual's gender expression or presentation. Would we require a medical classification of gender disorders[12] if our cultural system of classifying citizens was conceptualized outside of strict gender binaries? I argue that gender role expectations reliant on dimorphic sexed subject positions create a social space wherein deviations from the perceived norm become pathologized. Indeed, as Judith Butler points out, "insofar as social existence requires an unambiguous gender affinity, it is not possible to exist in a socially meaningful sense outside of established gender norms" (1986, 41). Those who transgress established social norms often engage in a daily struggle to have their subject positions acknowledged and to not be viewed as "abnormal" or pathological against the "norm". This struggle can be disruptive, but it is also the means through which change can be achieved in social and gender relations.

My goal here is not to speak for those who identify as transgender or transsexual, or to diminish the psychic pain and the social difficulties that transgender and transsexual individuals face. Instead I am interested in examining how transsexuality and Gender Identity Disorder (GID) as a medical and social condition are positioned within hegemonic narratives of gender in Canada. More specifically, I argue throughout this thesis that hegemonic discourses of gender inform public discourses about sex reassignment surgery (SRS) through the legitimization of subjects that conform to a normative gender presentation. I employ the term gender normativity to refer to a system of social conventions. This standardized system functions by organizing the world,

[12] The diagnostic category of Sexual and Gender Identity Disorders are outlined in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) published by the American Psychiatric Association, and used in Canada.

meaning that it describes and expects the world and its subjects to function in a normative way. This system maintains that there are only two sexes and genders and that they relate to each other in a specific manner – maleness and femaleness correspond to masculinity and femininity, and these modes of being relate to each other within the narrow scope of reproductive heterosexuality.

I do not believe that an expansion of accepted gender categories (i.e. the call for a multiplicity of gender positions), will alone overcome the struggle against gender normativity. Although the incorporation of previously deviant subject positions into the normative side of a gender taxonomy does influence the everyday lived experiences of subjects, this alone does not challenge the institutions and life experiences that are defined and regulated by this gender classification system. I do not claim here to have an answer to the "trouble" with gender. Nor do I claim to have an answer for the formulation of a social world beyond the categorization of its citizens through the organizing concept of gender. I am, instead, interested in examining how gender functions as a system in the Canadian context: what its rules and structures are and how transgressions against those rules are dealt with. It is imperative to also note that gender, as a system, intersects with and responds to other social systems – such as race, class, and physical ability – and shapes and regulates people's lives. Gender must also contend with other social signifiers, which may include class, sexual orientation, age, and ability. I believe that an examination of trans issues not only allows us to work towards social justice, but also, allows us to highlight assumptions about normative gender systems.

I will begin with an examination of some recent historical shifts in Western theoretical understandings of the relationship(s) between sex and gender emerging from

Simone de Beauvoir's *The Second Sex* (1953). While sex and gender were once thought to be naturally coupled, more recent discourses challenge the claim that gender identity and biological sex are inherently linked phenomena. Feminists, in particular, have taken up the differentiation between sex and gender and have argued for the emancipation of women (as well as men) from limiting and sometimes detrimental social expectations.[13]

Some feminists, such as Janice Raymond and Bernice L. Hausman, have viewed pre-operative transsexuals' discomfort with their biological sex, and the desire by some transsexuals for medical intervention, as indicative of a medico-social condition within strict narratives of sexual dimorphism[14] and gendered behaviour. Overall, the condition of transsexuality and transsexuals has been represented in a variety of ways by feminist and queer studies scholars: as pathologized subjects; as victims or "dupes" of a rigid, binary gender system; as co-conspirators in that system through stereotypical performances of woman- and man-hood; as gender outlaws; and as revolutionaries. I begin my survey with Simone de Beauvoir, who lays important groundwork for the progression from the 1950s to the present. It is important to contextualize this groundwork as it is the foundation of our contemporary approach to bodies. In particular, this articulation will become more apparent in Chapter Three, where I examine the representation of trans identity and the delisting of SRS in news media texts.

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[13] In contemporary Canadian context, overt forms of discrimination based on sex are prohibited. As outlined in the Canadian *Employment Equity Act*, S.C. 1995, c. 44, "conditions of disadvantage" and inequality in employment opportunities or benefits based on gender, disability and visible minority status are prohibited (Employment Equity Act, S.C. 1995, c. 44). However, there continues to exist arenas in which equality is still lacking. For example, the representation of women in public office is considerably lower than that of men. Women make up 52% of the Canadian population, but they represent only 22.1% of the seats in the House of Commons (Cool 2008).

[14] Sexual dimorphism refers to the distinct morphological features of the males and females of a species. As a biological model, sexual dimorphism views different behaviour between the sexes, and among each sex, as controlled by sex hormones. Theories of sex dimorphism, though variable in their details according to the species, apply to all vertebrates - of which humans are one species (Udry 562).

Changes in the Twentieth Century: Beauvoir's "One is not born a Woman"

As feminists have theorized about the relationship between sex and gender in a variety of ways, it is significant to note that the categories "sex" and "gender" contain a medley of meanings, which results in a certain level of ambiguity as to the signification of those meanings. According to Diane Richardson, prior to the 1960s, "gender referred primarily to what is coded in language as masculine or feminine" (3). Sex was conceived of in terms of binaries: male/female; man/woman; masculine/feminine. Sexual difference was conceived of as the natural form, that which biologically grounded gendered modes of being. This essentialist viewpoint was challenged by social constructionist accounts that emphasized social and cultural factors, not all of which denied the involvement of biology. During the 1960s, the Western[15] meaning of gender shifted through its partial

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15 My discussion of the distinction between sex and gender is positioned within this historical period in Western notions of the relationship between the two terms and is not necessarily reflective of other cultures, historical periods or theoretical positions. For example, Mia Nakamura argues that the Western concept of "identity" (and by extension gender identity) is not an indigenous concept in Japanese culture (though the concept "identity" is now used as a foreign loan word). Nakamura reminds us that discussions of "gender" and "identity" are culturally specific, and that they do not always translate onto other cultures with natural ease. As well, it should be noted that at times, non-Western cultures are examined uncritically through Western theoretical lenses. In particular, discussions regarding the social acceptance of the *hijra* of India, or the concept of "berdache" [sic] among North American First Nations have been employed, at times nostalgically or in a romanticizing way, as examples of "other" culture's acceptance of gender variance without much attention to each culture's social relation to these groups. For a further discussion of this point, refer to Towel and Morgan (469-497). Alternatively, the contemporary Western discussion of transsexuality in Iran can also help us to understand how a Western lens has been employed to discuss and interpret a non-Western cultural practice. Transsexuality in Iran has become a recent media topic both within Iran and internationally. Two recent documentaries exemplify this interest: Mitra Farahani's documentary, *Juste une Femme* (English title: Just a Woman) (2002), received the Teddy Jury Prize at the 2002 Berlin International Film Festival, while Tanaz Eshaghian's documentary *Be Like Others* premiered at the 2008 Sundance Film Festival - where it was nominated for the Grand Jury Prize and continued on to win three awards at the Berlin International Film Festival. News coverage of transsexuality in Iran has also been covered by, for example, BBC News, *The Guardian*, CBC News and *The New York Times*. As Najmabadi notes, the medical practice of 'sex change' – through surgery and hormone therapy – has occurred in Iran since the early 1970s. However, the recent international discussion of transsexuality in Iran is usually framed around the occurrence of subsidization for SRS by an Islamic state, or in comparison with discussions of punishments for homosexuals. In some Western perspectives, the increase in GID diagnosis and SRS is seen as an attempt by the religious state to control same-sex relationships. However, the issue is more complex than this argument presents, one component of which is the fact that it is sodomy that is illegal under Iranian law not homosexuality, in and of itself. Najmabadi maintains that Western coverage of transsexuality in Iran cannot be reduced to a view that it provides gays and lesbians with a "religiously

separation from the concept of sex, which became limited to biology and posited against the social. This sex/gender binary was first outlined in Beauvoir's seminal work, *The Second Sex* (1953), wherein sex is viewed as a biological process with differences between females and males in terms of the physiology of the body, and gender is viewed as a cultural phenomenon with "social meanings and value attached to being female or male in a given society, expressed in terms of the concepts femininity and masculinity" (Richardson 5). Beauvoir presents the argument that gender is socially constructed; that "masculinities" and "femininities" should be understood as social constructions rather than biological determinations. For Beauvoir, gender roles are "the cultural interpretations of our biologically given sex" (Richardson 6). She writes:

> One is not born, but rather becomes, a woman. No biological, psychological, or economic fate determines the figures that the human female presents in society; it is civilization as a whole that produces this creature (Beauvoir 267).

Beauvoir's act of distinguishing between biological sex and social gender, therefore, provides scholars, including feminists, with the opportunity to separate social behaviour and activities within society from biological explanations. As Sally Hines notes, an understanding of gender as distinct from sex "allows for the recognition of *differently* embodied gendered identities and expressions, or of different ways of being women and men" (Hines 2008, 24). This distinction suggests that gender expectations are socially constructed and therefore changeable. Beauvoir's understanding of gender has since been adopted by other feminists, who have sought to highlight the ways in which individuals are socialized into gender roles ("sex roles"), and cultural and historical modes associated

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sanctioned legal alternative" (25). This situation is further complicated because although in the legal context of contemporary Iran, transsexuality is legal and SRS is state subsidized, in the cultural context transsexuality is understood, overwhelmingly, as shameful (Najmabadi 23-42).

with women and men.[16] Beauvoir's work presents the sexed body as the material entity out of which a culturally contextualized gender emerges and is, at the same time, imposed upon. Beauvoir's static approach to the body, which situates sex as a constant aspect of being human, has, since, been contested.[17]

Beauvoir's separation of sex from gender is of particular significance in understanding transsexual narratives of living in the wrong body. It is in the space opened up between "social gender" and "biological sex" that transsexuals are able to configure a subject position. Patricia Elliot, in summarizing Trish Salah, notes, "transsexuals locate themselves within the categories of a binary system in order to establish congruence between sex and gender and to claim their right to live as men and women" (Elliot 9). The ability to distinguish between the sexed materiality of the body and expected/accepted gendered behaviours means transsexuals can lay claim to a gender identity separate from their biologically sexed body. In the process, such actions can constitute a resistance to essentialist[18] or heteronormative[19] assumptions of the relationship between the body/sex and gender.

Some feminist, queer and transgender theorists – such as Judith Butler and Sandy Stone – have adopted trans theories in their work, celebrating and pointing to the

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16 Of particular concern has been the ways in which becoming gendered limits women due to gender role expectations and gender inequality.

17 For a further discussion on this point, please refer to the section on "Queering Sex/Gender" in which I outline Judith Butler's view that our perception of the category sex is influenced by our shared linguistic norms.

18 The term essentialist is derived from "essence" and is used here to highlight belief in the assumed intrinsically or unchanging properties of a phenomenon (such as an unchanging or universal "female nature"), in opposition to it being a social or ideological construct, or influenced by such fields.

19 I use heteronormative here to refer assumptions that sustain particular institutions and practices. Stated otherwise, heteronormativity refers to a normative sexual practice (the boundaries of heterosexuality) that orders everyday existence in terms of both sexuality and gender, and affecting both those within and those outside of its boundaries.

(perceived) potential for transgressive expressions and lives as examples of how to live gender variance, or as tools to criticize the sex/gender binary.

Moving Forward from Beauvoir:

In the 1990s, the term transgender emerged as a signifier of those actions and identities that somehow transgress traditional conceptions of sex and gender. Susan Stryker describes transgender as "an umbrella term that refers to all identities or practices that cross over, cut across, move between, or otherwise queer socially constructed sex/gender boundaries" (Currah 4). Trans is similarly employed here as an inclusive term for individuals who transgress social conceptions of gender lines and gender expression, but not necessarily sexual orientation. I include within the larger trans(gender) community transsexual individuals who have transitioned – or wish to transition – from their assigned sex/gender at birth to live full-time as a member of another sex/gender.

I make use of Jean Bobby Noble's argument that although transsexual and transgender subjects transcend "the discourses of the sex/gender system that ground all meanings of gender in the appropriately sexed body" (Noble 17), such subjects still find themselves articulated by gender. They continue to perform gender difference even if the body that performs that gender is – to borrow Noble's phrasing – a 'transnatural' body produced through medical and surgical procedures. In some instances, individuals may self-identify as transsexual even though they have rejected, or been denied access to, the use of medical intervention. A decision to employ medical aid in bodily transitioning may depend on a variety of factors, such as financial constraints, access to facilities and support groups, health concerns, cultural background, and/or religion.

Overall, how transsexual bodies are situated within a society's gender system – as legitimate bodies, as marginalized but acknowledged bodies, or as unacknowledged bodies – impacts not only *those* bodies but *all* bodies caught within the gender system. Within feminist thought, disassociating gender identity from biological factors has not been without negative reactions. In particular, some feminist theorists – such as Janice Raymond, Marcia Yudkin and Bernice Hausman – have been particularly hostile to transgender practices. Although these theorists approach the condition of transsexuality from distinct theoretical positions, they all ultimately position transsexuals as victims of culture, as a threat to "women", and as pathological. It is to their critique that I now turn.

Feminist Critique of Transsexuality

One of the key detractions of transgendered subjectivity can be found in Janice G. Raymond's *The Transsexual Empire* (1979), which contains two central arguments: first, that sex and gender are inherently co-dependent categories; second, that "transgender practices are oppositional to the values and politics of feminism" (Raymond 1979, 29). Raymond states that it is impossible to separate sex and gender due to the fact that sex is chromosomally dependent, and therefore, secured at birth and unchangeable. Her conceptualization assumes that biology determines destiny, that chromosomal sex dictates socially constructed gender. She argues that while anatomical (genital or gonadal) sex can be altered with the use of plastic surgery – with endocrine or hormonal sex also susceptible to alteration through hormonal treatments – it is nonetheless

> biologically impossible to change *chromosomal* sex. If chromosomal sex is taken to be the fundamental basis for maleness and femaleness, the man (sic) who undergoes sex conversion is *not* female (Raymond 1979, 10, emphasis in original).

Raymond configures transsexuality as a (genetic) male[20] practice, created by a patriarchal and oppressive medical system whose aim is to construct servile women. She views transsexuals as undergoing "superficial, stereotypical, and artifactual changes that reinforce socially constructed roles and identities" (Raymond 1979, 188n).

In this way, Raymond suggests that "male-to-constructed-female"[21] transsexuals are used as a means of colonizing feminist identification and politics, and for gaining access to hard-won female only space (1979, xx). The medical system, therefore, constructs women from male bodies as an alternative to biological women – making them obsolete – and penetrating women's sense of self in every way: "Male-to-constructed-female transsexuals attempt to neutralize women by making the biological woman unnecessary – by invading both the feminine and feminist fronts… [while] Female-to-constructed-male transsexuals neutralize themselves as biological women and also their potentially deviant power" (Raymond 1979, xxv). Ultimately, Raymond views masculinity and femininity as the "social constructs and stereotypes of behavior that are culturally prescribed for male and female bodies respectively" (1979, 3). She claims that transsexuals reject one socially prescribed mode of being masculine or feminine and gravitate toward the other. Thus, for Raymond, "the *First Cause* of transsexualism is a gender-defined society whose norms of masculinity and femininity generate the desire to be transsexed" (1979, 16).

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[20] For Raymond, it is predominantly genetic males who undergo SRS. In her theorization, "female-to-constructed-males" [sic] are "tokens" of an oppressive patriarchal system, and function to promote the illusion that transsexuality is a human, instead of a male, problem.

[21] Raymond employs the term "male-to-constructed-female" to indicate the inability of genetic males to truly change sex, as "[t]he pattern of sex chromosomes is present and unchangeable in every body cell, including blood cells" (1979, 7).

Sandy Stone notes that until the early 1990s, Raymond's *The Transsexual Empire* remained "the definitive statement on transsexualism by a genetic female academic" (223). Such an extreme feminist position reproduces a binary model of gender as reliant on biological understandings of sex as fixed. It reads transgender and transsexual individuals as reproducing gender norms and denies the self-identified gender of transsexual persons. Raymond's argument also assumes that the desire to alter one's body in order to align it better with one's gender identity is inherently an antifeminist stance, and that sex reassignment surgery is required for the expression of all trans identities. Raymond's narrative denies the transsexual as a real person with a specific biography and, as such, has caused political and personal harm towards trans individuals.[22]

Raymond's homogenous approach to the category transsexual also denies the variety of trans expressions and modes of self-identification that exist within the community, and take for granted the numerous ways in which individuals exist in the real world. Within Raymond's theorization, transsexuals are guilty of practicing misogynist forms of femininity by perpetuating gender essentialism and are hence co-conspirators with patriarchal oppression (Heyes 1101). I find such claims problematic because they deny the agency of the transsexual individual and concentrate on MtF [Male-to-Female] practices for political reasons. As well, Raymond's mode of argumentation grants certain individuals – mainly herself – as capable of judging "true" femininity or appropriate gender presentations and feminist goals.

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[22] Carol Riddell's response to Raymond - originally published as a pamphlet within a year of *The Transsexual Empire*'s publication – expands on such criticisms from a transgender feminist position specifically by drawing on her own experiences at the Gender Identity Clinic in London, UK. Riddell writes: "Ms. Raymond denies my existence as a woman, and believes that the aim of trans-sexual feminists is to seek publicity and, as agents of the patriarchy infiltrated into the women's movement, to sow dissention into it. As a trans-sexual woman and a feminist, I neither seek publicity, nor am I an agent of patriarchy. But my right, and that of other trans-sexual women and men to exist is threatened by this book" (145).

Marcia Yudkin (1978) also questions the definition of MtF transsexuality. Following Beauvoir, Yudkin asks, "What is a woman?" Specifically, Yudkin questions whether biological males[23] who have undergone genital surgery and hormone therapy, with cosmetic and behavioural changes to aid in their "passing" as women, can lay claim to the identity "woman". Yudkin considers MtF transsexuals as women in so far as she acknowledges their identification with female sex roles. In Yudkin's view, a MtF transsexual identifying as a woman is problematic because of the absence of an "uninterrupted past social identity as girls or women" (Yudkin 104). Here, Yudkin is referencing the social identity of "woman" and the accompanying pressures and limitations of the female sex role (citing such examples as pregnancy, menstruation, and rape), which, she believes, MtF transsexuals have escaped through their positions as boys/men prior to transitioning.

Yudkin views the political dimension of transsexualism as one that exists because of strict social identities. She argues that the "condition" of transsexualism can exist only if the social identity of "woman" is kept distinct from the social identity of "man," and that such identities are deemed incompatible with a biological identity as male (for the category woman), or female (for the category man) (Yudkin 102). Therefore, transsexuals are the victims of a cultural system that insists on binary genders – what Yudkin refers to as sex roles – tied to a presumed dichotomy of the sexes (Yudkin 103). Transsexuals are then the

> victims of our society's taking sex and sex roles as the center of one's private and public identity, victims of society's insistence that one's personality, desires, likes and dislikes, outward appearance, and so on, be at one with one's biological and social identity (Yudkin 100).

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[23] Female transsexuals are not explicitly discussed by Yudkin.

In *Changing Sex: Transsexualism, Technology, and the Idea of Gender* (1995), Bernice L. Hausman asserts that, "the development of certain medical technologies made the advent of transsexualism possible" (1995, 7). Hausman argues that the distinction between biological sex and social gender is rooted in the development of medical treatments and practices of the 1950s addressed with intersex conditions.[24] In Hausman's opinion, such medical advances were not necessarily used to disentangle the false claim that only two genetic sexes exist. Rather, advances in the scientific field of endocrinology and plastic surgery provided medical institutions with "the tools to enforce sexual dimorphism – not only to examine and describe it," particularly in the ways intersex infants were re-sexed as either male or female (Hausman 1995, 38).

Hausman postulates that endocrinological advances and improvements in plastic surgery techniques were central components of the material conditions that allowed for the conceptualization of the condition of transsexuality in both "making" the transsexual through sex change, and in "envisioning" transsexuality as a new subjective category. It is only through the demand for a sex change that the presenting subject is constructed as a transsexual in Hausman's theory (Hausman 1995, 110). She writes, "by demanding technological intervention to "change sex," transsexuals demonstrate that their relationship to technology is a dependent one" (Hausman 1995, 110). Therefore, for

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[24] Hausman accredits the development of the term "gender" to John Money and the Hampsons' work with intersex infants in the 1950s. She states that Money employed the term "gender" in referring to "the social articulations of sexed identity" (Hausman 1995, 196). Money made use of the term gender in his academic work as a means of presenting the argument that in medical treatment of older intersex children, the child's gender role and orientation should be given first priority over the appearance of their external genitalia. This was in support of Money and the Hampsons' belief that gender awareness is established by the age of eighteen months (Hausman 1995, 96). It is important to acknowledge the different subject positions that adult transsexuals inhabit, and the variety of ways this differs from intersex infants. As well, I would like to maintain that the early development of the concept "gender" within medical discourses does not diminish the significant work that feminists have conducted through the use of "gender".

Hausman, transsexuality is reduced to its relations to the medical technologies and institutions that she claims produce the transsexual individual.

The above authors approach the condition of transsexuality in a problematic manner by treating it as a static category. Raymond's work, in particular, denies any form of agency in her discussion of transsexuals. For her, the transsexual functions as an object; a mold upon which a patriarchal medical system enacts violence against 'woman'. Raymond and Hausman, although theoretically different, construct transsexuality as pathology when they claim that trans people lack political perspective by implicitly positioning themselves within a patriarchal medicalized model. Both authors also argue that any attempt made by transsexuals – or, indeed, transgender individuals – to proliferate gendered subject positions ultimately connects back to binary logic. An understanding of "woman" (or "man") as a restricted category,[25] as Raymond and Yudkin postulate, remains contentious because it takes homogeneity for granted in these categories. In particular, understanding the category "woman" as based on biological configurations is problematic when taking into consideration Judith Butler's theorization that sex is as much about social construction as it is about gender.

Queering Sex/Gender

In *Gender Trouble* (1990/1999) and *Bodies That Matter* (1993), Butler challenges previous theorizations about an oppositional distinction between sex as biological and gender as social. Warning against biological determinism, Butler questions the naturalness of the category of sex, particularly in Beauvoir's theorization. For Butler, the

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[25] By restricted category I mean an understanding of "woman" as a stable or closed class whose membership is limited through specific defining characteristics such as a shared female history, or a specific chromosomal makeup.

sexed body does not simply function as the site upon which gender is enacted; the meaning of sex is always already established and interpreted through cultural understandings of bodily differences. Unlike earlier feminist articulations, Butler does not envision biological sex as the foundation upon which social gender is superimposed. Instead, she suggests, individuals read bodies as differently sexed through the category of gender. By arguing that the "gender acts"[26] – those repeated performances – that we enact affect our materiality, Butler maintains that our very perceptions of physiological differences become affected by social conventions and norms. In Butler's theorizations, our material reality is constructed and determined by our linguistic constructs. It is, therefore, impossible to articulate sex beyond a social construct since "there is no reference to a pure body which is not at the same time a further formation of that body" (Butler 1993, 10).

Accordingly, under Butler's theory of gender performance, it is impossible to differentiate between sex and gender. She writes that sex is "not simply what one has, or a static description of what one is: it will be one of the norms by which the 'one' becomes viable at all, that which qualifies a body for life within the domain of cultural intelligibility" (Butler 1993, 2). Therefore, the articulation of sex as a historical phenomenon that is socially constructed functions to destabilize the notion of biological materiality as static.

Although transsexualism demonstrates that a person's gender identity does not need to be determined by one's biological sex assigned at birth, the desire to make congruent one's biological sex with their self-identified gender requires the retention of

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[26] Butler writes: "Gender ought not to be construed as a stable identity or locus of agency from which various acts follow; rather, gender is an identity tenuously constituted in time, instituted in an exterior space through a *stylized repetition of acts*" (emphasis in original 1999, 190).

the analytical categories of gender and sex. For theoretical positions such as Butler's, this refusal to abandon sex and gender as distinct categories can be problematic (Elliot 9).

In light of Butler's theory of gender performance, transsexual narratives of "existing in the wrong body"[27] appear fallacious. If "there is no gender identity behind the expressions of genders...[and]... identity is performatively constituted by the very 'expressions' that are said to be its results" (Butler 1999, 34), can a transsexual desire for sex reassignment be legitimated through a claim to a distinct gender identity separate from biological fact? Butler's theory indicates that gender is a performance that is *done by* the individual rather than a stable presentation of *who* the individual is. As such, transsexual claims of experiencing a particular gender identity not connected to a biological sex can both fit and be rejected within Butler's notion of gender performance. Transsexual gender identities align with Butler's theories of performance[28] in that as a performance, gender is not reliant on an essentialist notion of binary masculinity and femininity tied to physiological makeup. However, Butler's performance theory can also be hostile towards transsexual gender identities because a free-floating notion of gender challenges claims of a 'true' or 'felt' identity.

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[27] Kate Bornstein, in her book *Gender Outlaw* (1995), articulates a personal response to the myth of the trans person trapped in the wrong body by noting, "I understand that many people may explain their preoperative transgendered lives in this way, but I'll bet that it's more likely an unfortunate metaphor that conveniently conforms to cultural expectations, rather than an honest reflection of our transgendered feelings. As a people, we're short on metaphors, any metaphors, and when we find one that people understand, we stop looking. It's time for transgendered people to look for new metaphors – new ways of communicating our lives to people who are traditionally gendered" (1995, 66).

[28] Butler makes use of the performative to discuss the production of gender. She argues that gender is a reiterated performative process that begins with the act of pronouncing a child is "a boy" or "a girl" (1999).

The transsexual desire to live as men and women can, therefore, be seen to both align with queer[29] politics, and to fall short of it. If queering is understood as challenging assumptions about hegemonic understandings of a fixed gender, then transsexuals queer such understandings through their desire for congruence, and through their challenge to the traditional associations of gender and sex as immutable. However, transsexuals may also be seen as falling short of queer politics through their reliance on – or their inability to transgress – the categories of sex and gender entirely.

Butler's desire to understand gender as unstable, as always fluctuating, contradicts a key component of the transsexual desire for alternative embodiment that is often achieved through medical intervention. Sex reassignment surgery is not to be undertaken lightly, and the real effects of it can be seen in the way the human body resists attempts at changes to its materiality, particularly present in surgical recovery time. I argue that Butler's call to engage in gender play[30] that undermines a sense of stable identity is incompatible with efforts to attain extensive, and painful, sex reassignment surgery. The same sense of gender play could be achieved through the ability to pass or shift between signifying a sex (or no sex) by manipulating external presentations of the body.[31]

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[29] Annemarie Jagose articulates queer as: "those gestures of analytical models which dramatise incoherencies in the allegedly stable relations between chromosomal sex, gender, and sexual desire.... Institutionally, queer has been associated most prominently with lesbian and gay subjects, but its analytic framework also includes such topics as cross-dressing, hermaphroditism (sic) gender ambiguity and gender-corrective surgery. Whether as transvestite performance or academic deconstruction, queer locates and exploits the incoherencies in those three terms which stabilise heterosexuality. Demonstrating the impossibility of any 'natural' sexuality, it calls into question even such apparently unproblematic terms as 'man' and 'woman'" (Jagose 3).

[30] Gender play refers to instances or acts of gender bending or gender ambiguity that are often intentional and deliberate. I comprehend gender play as similar to the notion of 'genderfuck,' viewed as an intentional disruption of gender norms achieved through manipulation of behavioural patterns or performances.

[31] In most situations, we do not expose our genitalia as a means of legitimizing our sexed subject position when we come into contact with others. Rather, it is through secondary characteristics that we present ourselves as possessing a certain identity. Such characteristics can include the (presentation of) bodily manifestations such as breasts, hips, Adam's apple, voice pitch, and/or outwardly and culturally

Although some gender variant individuals are able to live manageable lives with unstable gender identities, for many transsexuals, "the search for a gender home is paramount" (Elliot 22).

Although Butler's theory of gender as performance has been greatly influential, I agree with Toril Moi's suggestion that such arguments become increasingly abstract and removed from specific bodies and their lived materiality. Moi laments the loss of the body, or embodiment, in current discussions of the sex/gender binary, and she challenges the usefulness of the concept of gender.[32] Instead, Moi calls for the reconstitution of the body through Beauvoir's framework of lived experience (drawn from her understanding of existential phenomenology) and the view of the lived body as a situation[33] in order to guard against biological reductionism or gender essentialism. Moi argues that the concept of the lived body, while referring to specific physical attributes of the lived body[34], does not restrict theoretical discussions to a dimorphic categorization of sex or heterosexual normativity. The lived body does not trap itself within the nature/culture argument with which the sex/gender approach must contend because the body exists within a specific socio-cultural structure and history. Moi writes,

> [a]lthough our biology is fundamental to the way we live in the world, biological facts alone give us no grounds for concluding anything at all about the *meaning* and *value* they will have for the individual and for society. At the same time, however, biological facts cannot be placed outside the realm of meaning [emphasis in original] (Moi 69).

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inscribed manifestations such as clothing, makeup and hair that are taken as external representations of the perceived sexed body beneath.

[32] Moi variously refers to gender as social norms, ideology, power and regulatory discourses.

[33] The lived body as a situation refers to the materiality of the individual's body in relation to specific environments and culturally specific processes that ground the individual's project (what s/he wishes to achieve) (Moi, 65-66).

[34] Here, Moi is referencing other markers of differentiation– such as race – that alongside sex/gender situate the body within an environment, but which are experienced by each individual differently and which, therefore, escape abstract generalizations.

I find Moi's emphasis on the meanings accorded to bodies within society significant and reflective of my own interest in gender systems. Although Moi questions the usefulness of gender as an analytical category, I wish to retain it. The concept gender remains useful for a discussion of discourses and social structures, and their connotations for individuals. Gender can provide a way of speaking of social structures and their normalizing processes. In order to retain gender as an analytical category, I propose to incorporate Iris Marion Young's approach to gender. Young maintains that gender is one way of socially positioning lived bodies in relation to one another and within historically specific institutions. Institutions, such as education and the law, may privilege and provide benefits to some persons while constraining others. Young argues that such institutions and social processes influence the way individuals act and reproduce power relations (Young 422). Therefore, an individual's subjectivity is comprised and conditioned, in part, by socio-cultural facts and expectations beyond their control. At the same time, the individual may act in response to such facts in their own manner (Young 418). In this manner, Young does not deny that each person "is a distinctive body, with specific features, capacities, and desires, that are similar to and different from those of others in determinate respects" (Young, 417).

The individual, and their body, is then comprised of both the very real materiality of their existence and the social systems in which they exist. For trans persons the desire to alter their bodies has real effects not only on individual bodies but also on how those bodies are signified and read by others. Therefore, if the condition of transsexuality is understood, in part, as the desire to live as a member of the "opposite" sex, sex

reassignment surgery can be viewed as an attempt to address the body's social position.[35] The body is the site that is made to become congruent with an individual's gender identity through sex reassignment surgery. The confusion or disordered mode of being associated with transsexualism arises from the individual's behaviour that confronts socially prescribed modes of being their sex. It is here that ambivalence regarding the clinical diagnosis of Gender Identity Disorder (GID) emerges.[36] By this ambivalence, I mean that a clinical approach to GID must contend with an understanding of gender that is – for the most part – static. The desire to physically transform from one sex to the other takes for granted the underlying assumption that one gendered mode of being (masculine) corresponds, naturally, to only one sexed body (the male). This desire to be "the opposite sex" presupposes a mutually exclusive definition of what each sex is like. The question remains whether sex reassignment surgery is envisioned as a policing tool for the normative gender system, or as a tool that can be used strategically to transgress binary understandings of sex and gender, or both.

Trans Voices

The desire to alter one's body also affects how others perceive and read trans bodies. The notion of "transgressing" binary understandings of sex and gender, therefore, combines both actions on the parts of the trans person and the actions of others. Feminist scholars, such as Judith Butler and Janice Raymond, have engaged in significant debate about whether transsexuals "challenge" or "reinforce" gender norms, and there is a

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[35] The DSM states that adult subjects who suffer from GID may present preoccupations that manifest as "an intense desire to adopt the social role of the other sex or to acquire the physical appearance of the other sex through hormonal or surgical manipulation" (DSM-IV-TR, 2000). The DSM also outlines the diagnostic features of GID in children and adolescents.

[36] In Chapter Two, I examine in greater detail this ambivalence surrounding gender discomfort as a potential disorder, and those issues surrounding a clinical diagnosis of gender variance as potentially pathologizing.

plurality of positions within trans scholarship and activism concerned with the topic of "transgressing the gender binary". In this section, I highlight some of the ongoing debates between trans writers, including texts by Kate Bornstein, Riki Wilchins, Julia Serano and Viviane Namaste. Not all trans writers agree about the expression of trans identity, and how – or even whether – it challenges the traditional gender binary. There are particular disagreements amongst those writers who advocate for transgender politics and the disruption of gender as a system through the ambiguity or fluidity of gender expression and identity, and those writers who wish to challenge the institutional framing of transsexuals, including the dominant ways transgender scholarship presents transsexuals and their desires.

In a response to Janice Raymond's discussion of deception undertaken by transsexuals Kate Borstein notes, "personally, I agree that hiding, and not proclaiming one's transsexual status is an unworthy stance, more heinous if one's invisible status is maintained with the purpose of gaining power" (1995, 76).[37] Such a sentiment – that of "passing" and/or failing to highlight one's transsexual status is unworthy – works to regulate how transsexuals should live their lives. It is a judgment statement in alignment with a particular transgender political cause, which may not be in agreement with how some transsexuals wish to live their lives as men and women. As Julia Serano notes, "the word 'pass' is used to shift the blame away from the majority group's prejudice and toward the minority person's presumed motives and actions" (177). This definition of passing explains why, upon discovery, those individuals who are able to "pass" are often accused of "deception". As well, such sentiments highlight one way of living as a trans

[37] I would like to draw attention to the fact that not every trans person can (a) "pass" and (b) afford to be "read" as a transsexual, or (c) want to outwardly identify as transsexual in every situation.

person, with a particular emphasis placed on dismantling the dominant gender binary. The desire to "shatter the gender binary" is described by some activists and theorists – such as Bornstein – as the end goal of trans activism. Bornstein claims that lesbian and gay men are also excluded by culture for their violations of gender codes – which occur in the public domain in contrast to private sexual practices – and hence share a similar stigma with transgendered people: "the stigma of crimes against gender" (1995, 134). In order to overcome patriarchal oppression and permit a "true revolution of sex and gender" (135), Bornstein calls for the reclamation of the word transgendered to be more inclusive and to mean "transgressively gendered"; only then will there be a healthy-sized "group of people who break the rules, codes, and shackles of gender" (135).

Although Riki Wilchins states in her book, *Read My Lips* (1997), that she is not interested in being part of a transgender or transsexual movement based on identity politics, she goes on to argue in *Queer theory, Gender Theory* (2004) that those people who are most interested in the issues of gender expression and identity are transgendered:

> Transpeople are still the only community who will readily identify the problems around gender. Almost everyone else is too ashamed to do so, or chooses to reinterpret issues with the gender system through sex or sexual orientation. But for transpeople, having issues with gender is the basis for common identity. Transpeople have no choice but to attack gender norms, because their very existence is in itself a challenge to gender norms, no matter how well they might visually conform to them (2004, 142).

However, both Julia Serano and Viviane Namaste argue that the belief that trans experience and existence automatically functions to challenge gender is not universally shared. In her 2007 book, *Whipping Girl: A Transsexual Woman on Sexism and the Scapegoating of Femininity*, Serano aims to debunk misconceptions about gender and transsexual women by showing that trans persons are "ridiculed and dismissed not merely

because [they] 'transgress binary gender norms,' as many transgender activists and gender theorists have proposed, but rather because [they] 'choose' to be women rather than men" (4). Serano proclaims the problematic nature of the sentiment that those who reject gender are more politically progressive due to their more transgressive position – as the most "gender-radical" – against other trans individuals who are comfortable within more traditional genders. Such a view disparages those who fail to be seen as rejecting traditional gender. As Serano notes, it becomes problematic

> when we move beyond simply claiming that 'transgressive' genders are just as legitimate as any other gender, and into the realm of arguing that 'transgressive' genders are *better* than 'non-transgressive' genders. In other words, it is the value judgments often placed on 'transgressive' gender identities and expressions (rather than those specific identities and expressions) that [she aims to critique in her work] (383n).

In exploring the history of gay rights movement in the 1970s, Serano focuses on the emphasis that gay activists placed solely on sexual orientation.[38] Serano positions the narrowing of 1970s activism in the separation of "sexuality-queers" from "cross-gender queers" (355). She views the queer and transgender movements that came into their own in the 1990s as a response to the unified "sexuality-queers" of the previous mainstream gay rights activism. However, Serano expresses concern with the trend within the transgender/queer community[39] to praise certain gender and sexual expressions and identities based on their nonconformity (346). Serano refers to this trend as "subversivism". As a trans author, she argues

> The more inclusive the word 'transgender' becomes, the more thoroughly the voices of transsexuals and other cross-gender/cross-living individuals

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[38] Riki Wilchins also draws on the history of gay rights activism, and the historical separation between "gayness" and gender. She argues, "Transcending gender stereotypes had always been a subtext for gay rights" but gay rights advocates began to back away from issues of gender, to the point that gender is no longer discussed as a gay issue (2004, 21).

[39] Serano specifically notes that this point of view is not applicable to all queer/trans folks.

> are drowned out by those who do not share our perspectives and experiences. This 'cissexualization' of transgenderism has taken a devastating toll on the ability of transsexuals to articulate our own perspectives and visions for gender activism. Rather than being listened to and appreciated on our own terms, we are instead forced to adhere to lesbian/gay rhetoric and values in order to have a voice within our own community. One can see this … in the way that queer theorists, ignorant of their own cissexual privilege, nonconsensually ungender us (or blur the distinctions between us and other queers) in order to artificialize genders; claim that 'all gender is drag' without recognizing how dismissive that is to the transsexual experience; and ignorantly apply the 'gay rights' tactic of calling for the all-out demedicalization of transgenderism without considering the effects this would have on transsexuals' ability to access and afford hormones and sex reassignment procedures (356).

Instead of focusing on "shattering the gender binary," Serano argues for the challenging of all forms of "*gender entitlement*, the privileging of one's own perceptions, interpretations, and evaluations of other people's genders over the way those people understand themselves" (emphasis in original, 359).

Similarly, Viviane Namaste disagrees with the strong emphasis placed on transgender political activity within Anglo-American scholarship.[40] Her work highlights the shortcomings of feminist concerns with questions of identity, particularly those questions about "whether or not transsexual women are women" (2005, 127). She argues that many feminist and queer scholarship and political actions concerned with identity fail to properly take note of transsexuals of colour by excluding racial and ethnocultural diversity in their analysis. She writes, "when we restrict ourselves to the *identity* of sex change, we simultaneously limit our understandings of social change" (2005, 19). Namaste says that current feminist and queer scholarship and activism fail to consider "the circumstances of the everyday lives and working conditions of most transsexual prostitutes, prisoners, and drug users" (2005, 127). She proposes to move away from

[40] Viviane Namaste is referencing the production of theory that takes place in English, and which is dominantly located in the US, UK, English Canada and Australia.

issues of identity and instead focus on institutional questions that frame transsexuals. Namaste calls for a commitment to language requirements outside of English, which she views as integral to both academic endeavours to gather, interpret, and analyze data, and to ground-level engagement with communities and the offering of services in activist work. She writes, "research that does not consider studies on transsexuals and transvestites written in languages other than English misses important theoretical and methodological insight concerning the everyday social world for [transgender-transsexual] people" (2000, 66). Specifically, she critiques queer theorists and transgender theorists who reproach transsexuals for failing to challenge normative gender, who are able to change sex and live undetected as transsexuals. She goes on to argue,

> it seems to me that on a very fundamental level, transsexuality is about individuals who change our physical bodies because we want to move through the world on all levels in a sex and gender other than the one assigned to us at birth. Transsexuality is about the banality of buying some bread, of making photocopies, of getting your shoe fixed. It is not about challenging the binary sex/gender system, it is not about starting the Gender Revolution (2005, 20).

Ultimately, this is what Namaste views the failure of identity debates to be. She articulates a reality that she views affecting thousands of transsexuals who do not make sense of their lives in a lesbian/gay framework. Namaste cites the works of Leslie Feinberg, Kate Bornstein and Riki Ann Wilchins, noting "all three elaborate at great length on the value of a coalition between lesbians/gays and the transsexual/transvestite movement" (2005, 51). While a coalition is not, in and of itself, problematic, in Namaste's view it is a problem that lesbian (and gay) scholars come to "stand in for an entire transsexual community" (2005, 51), particularly in the framework of transgender

political activity within Anglo-American contexts (2000, 62).[41] Drawing on her own involvement and observations within transsexual communities, spanning over 10 years, Namaste argues, "most transsexuals do not want to have any formal association with the lesbian/gay communities" (2005, 51).

In addition to a lesbian/gay frame of reference, in Namaste's view, "An additional problem is that these debates actually prevent us from engaging in any kind of broad social analysis of how [trans] lives are managed by institutions" (2005, 22). Namaste presents the political works of Wilchins in relation to transgender bodies and identities that are positioned in a broader process of social change, of a call to disrupt the sex/gender binary. In Namaste's view, Wilchins's lobbying for the delisting of Gender Identity Disorder from the *Diagnostic and Statistical Manual of Mental Disorders* poses problems for state/provincial or private insurance company funding for SRS (2005, 7-8).

Margrit Eichler[42] views the allocation of resources – such as medical personnel's limited time and expert training, and hospital and clinic resources – towards reassignment surgeries in the twentieth century as indicative of Western culture's "extreme intolerance of sexual ambiguity" (Eichler 281). Eichler sees this as suggestive of the acceptance of dominant sex role ideology. Indeed, a reliance on sex-appropriate behavior, of limited legitimated forms of femininities and masculinities, contributes to transsexual individual's understanding of appropriate behaviour. At the heart of Eichler's

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41 Similarly, Henry Rubin contends that the majority of Anglo-American scholarship promotes transgendered people aligned with queer politics or who define themselves as queer. Such an action works to exude those transgendered or transsexual people whom identity as otherwise, such as heterosexual FTM or MTF transsexuals. "Queer appropriations and the new movement among some transgenders to resignify themselves in a queer registrar carry an implicit critique of transsexuals who choose not to queer their identities" (1998, 276).

42 Eichler is currently with the Department of Sociology and Equity Studies in Education, at the Ontario Institute for Studies in Education/University of Toronto. Her work focuses on the examination of the arbitrariness of sex and gender dichotomies. She views sex reassignment surgery as a medical way of supporting the traditional gender role dichotomy.

conceptualization of sex reassignment surgery is the association of certain behaviours and character traits with specific anatomical manifestations. She views sex reassignment surgery as a way for the individual to bring their body in alignment with their preferred behaviour patterns. If certain sets of behaviours are restricted for certain bodies, and if the individual wishes to continue to act in way that is not congruent with their sexed body, the body is made to align with the desired set of behaviours.

Medical support for sex reassignment surgery, Eichler argues, shows us that physicians agree that certain behaviour patterns are appropriate only for a member of one sex and not the other. She writes,

> Performing the operation ... reinforce[s] the idea that behavior and character traits are legitimately determined by one's body, in the face of the evidence that suggests that our sex identity is imposed on a sexually largely or entirely undifferentiated character structure and that, therefore, sex identity is a social rather than a biological product (Eichler 289).

For Eichler, there is a logic in the patient and physician approach to surgery, which reads as follows: If gendered characteristics and patterns of behaviour are viewed as being determined by biological sex, it follows that in instances in which biological sex and gender identities are not congruent, biological sex must be altered in order to uphold accepted modes of behaviour. In her view, existing power relations (what Eichler calls "social pathology") are able to overcome threats to its (ideological/discursive) dominance by treating transsexualism not as the result of the imposition of restrictive sex structures but by treating transsexualism as individualized.

I approach sex reassignment surgery from a less cynical perspective. I agree with Eichler that a gender system that monitors and restricts gender behaviour is highly problematic. I also acknowledge that reassignment procedures remain contentious due to

its very real effects on bodies. As a medical procedure sex reassignment surgery should not be undertaken lightly. Caring and committed medical staff must be involved. As I discuss in greater detail in the following chapter, I believe that the clinical diagnosis of Gender Identity Disorder presents more challenges than the procedures of sex reassignment surgery, in part because the categorization of Gender Identity Disorder presupposes normative gender practices and behaviours and can function to identify gender variant practices and identity as disorders.[43] I do not wish to romanticize the difficult process of attaining access to sex reassignment surgery, nor do I think all gender clinics and regulatory bodies are free of harmful components. As Vancouver-based psychotherapist Christopher Shelley notes, although some gender clinic personnel are trans advocates, others can, and have at times, been complicit in regulating or gate-keeping access to treatment and surgeries based on an essentialist view of "authentic" gender performances or a personal aim to produce conformity to "acceptable norms" (4). Shelley outlines a range of four positions for those upholding the aims of normative adjustment. First, there is an "outright denial of the authenticity of all claims to being mis-sexed and an associated rejection of sexual reassignment surgery" (Shelley 4). Patients are expected to conform to their assigned birth sex. Second, there is a willingness to accede to the idea that sex reassignment surgery is the only solution for individuals with persistent "delusions" about being mis-sexed. Third, there is a "parsimonious acceptance that a small number of subjects are genuinely mis-sexed, with authorization of SRS contingent on the patient's agreement to cross into stereotypical sex/gender conformity", and finally, an acceptance of the legitimacy of transsexual claims to being

[43] Alternatively, I view the procedures of sex reassignment surgery as attempts to alleviate psycho-social pain.

mis-sexed, "accompanied by rejection of TG [transgender] requests for partial surgeries or hormone treatment alone, eliminating acceptance of border-crossing and in-between-ness as legitimate" (Shelley 4-5). Here, there is a binary that plays out in which the clinician is the "sane" expert, capable of curing the "insane" deviant. Indeed, attempts to either discontinue treatment full stop, to regulate access based on the assumption that certain individuals can better "pass" in their desired gender, or to proceed with the notion that anyone who requests sex reassignment surgery be granted access all pose ethical concerns.

In my next chapter, I examine in greater detail the clinical definition of Gender Identity Disorder and highlight key problematic components of a medical diagnosis of gender dysphoria. I explore arguments for the continuation of SRS alongside calls for the reformulation of the GID diagnostic criteria in medical discourses. As well, I examine the contribution of Canadian legal cases, alongside medical discourses, in constructing and reflecting an official discourse on transsexuality. Finally, I comment on the results from Phase I of the Trans PULSE Project to indicate sites of informational and institutional erasure with regards to trans health issues.

2. Expert Knowledge and Cissexual Privilege: The Legalization and Medicalization of Trans Identity

> *"It is not enough to claim that human subjects are constructed, for the construction of the human is a differential operation that produces the more and the less 'human', the inhuman, the humanly unthinkable" – Judith Butler 1993, 8*

We are able to speak of the 'pathological' only in relation to a pre-established 'normal': "Every conception of pathology must be based on prior knowledge of the corresponding normal state, which is, inevitably, value-laden" – George Canguilhem, 51

In this Chapter, I consider three intersecting fields of expertise related to transsexuality. These three forms of discourse are an essential component of the ways we think of the relationship between sex/gender and transsexuality. These discourses reflect, produce and disseminate knowledge and truth about transsexuality and sex reassignment surgery. In the next two chapters, I build the argument that medical and legal discourses intersect to legitimate one another, and, that such discourses become re-inscribed in news media coverage of transsexuality. In this chapter, I examine the Canadian legal discourses that regulate transsexual subjects in relation to national and provincial systems and take civil marriage as a case study; the medical discourses as outlined by the American Psychiatric Association's Gender Identity Disorder diagnosis in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM); and the Trans PULSE Project[44] currently underway across Ontario. These official legal and medical discourses intersect, inform and work together to provide an understanding of transsexuality and sex reassignment surgery that is taken up by the four Canadian newspapers examined in the next chapter: *The Globe and Mail*, *National Post*, *The Toronto Star* and *Toronto Sun*. In this chapter, I

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[44] The Trans PULSE Project is a comprehensive project aimed at documenting the lived experiences of trans people in Ontario. The purpose of the Trans PULSE Project is aimed at "**P**romoting health and wellness in trans communities through **U**nderstanding our diverse experiences and **L**ives and using this knowledge to help improve the health of trans communities through better **S**ervices and genuine **E**quality" (emphasis added, Trans Pulse n. p.).

maintain that trans individuals wishing to have their affirmed subject position acknowledged by the Ontario government must submit themselves to a medicalized system by first receiving acknowledgment of their gender dysphoria by being diagnosed with Gender Identity Disorder, then through the approval for sex reassignment surgery by the Centre for Addiction and Mental Health (CAMH), and finally the submission of proof of transition to the Registrar General before attaining recognition. Trans individuals are hence often thought of in medicalized terms. While access to health care remains only one aspect of transsexual lived experiences, it remains a significant factor. As the research conducted by the Trans PULSE Project aims to highlight, the social determinants of health and health care remain of significant concern within the trans community. The research conducted by the Trans PULSE Project and the results from Phase I of the project (published Sep/Oct 2009) highlight sites of trans erasure. As Viviane K. Namaste notes, "erasure is a defining condition of how transsexuality is managed in culture and institutions, a condition that ultimately inscribes transsexuality as impossible" (Namaste 4-5). Erasure, therefore, influences experiences with health care and other service systems wherein the trans individual is seen as an anomaly as the result of informational and institutional erasure (Bauer et al. 2009, 348).

Before an examination of the legal and medical discourses can take place, it is important to return to the concept of discourse. Foucauldian discourse can be thought of as a field in which possible statements about a given topic, area or object can be produced and become known. As a system of representation, discourse has the power to convey meanings about a given topic, allowing – or excluding – particular ways of speaking or

thinking at a given historical period (Cheek 1142).[45] Discourse "influences how ideas are put into practice and used to regulate the conduct of others" (S. Hall 72). It is in this manner that discourses determine who can speak, when they can speak, and with how much authority. In *The Archaeology of Knowledge*, Foucault writes: "Medical statements cannot come from anybody; their value, efficacy, even their therapeutic power, and, generally speaking, their existence as medical statements cannot be dissociated from the statutorily defined person who has the right to make them" (2005, 56). Those who are deemed experts have the ability to speak of truths (Foucault 2005). Health care professionals – such as psychiatrists, psychologists and other mental health care providers – demonstrate this aspect of discourse through the authority they assume in speaking from an expert position about trans-related health concerns. The authority accorded to health care professionals reflects the effects of power, which constitutes itself through knowledge (Cheek 1143; S. Hall 77). Power enables particular knowledge to be produced or constrained, as well as the creation of new discourses and discursive regimes; understood otherwise, power can shape what a society "knows" as truth.

The types of gendered expressions and behaviours that are taken to be natural or normal provide us with glimpses of truth about gender. Gender permeates our structured world in a variety of ways, influencing legal definitions, medical concepts and childrearing patterns. In contemporary Canadian culture, it is taken as natural that a male

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[45] In *The History of Sexuality: Volume 1*, Foucault explores how 'the homosexual' as a specific kind of subject was produced through fields of expert knowledge in the nineteenth century. Foucault writes: "The nineteenth-century homosexual became a personage, a past, a case history, and a childhood, in addition to being a type of life, a life form, and a morphology, with an indiscreet anatomy and possibly a mysterious physiology. Nothing that went into his (sic) total composition was unaffected by his sexuality.... It was consubstantial with him, less as a habitual sin than as a singular nature.... The sodomite had been a temporary aberration; the homosexual was now a species" (1990, 43). A similar argument can be put forth for the creation of the transsexual as a specific kind of subject during the early twentieth century within psychoanalytical theory, and with advancements in endocrinological science and surgical procedures.

body should only signify a masculine gendered identity (and that a female body only signifies a feminine one). This naturalized understanding of gender is conceived as 'authentic' against alternative modes of enacting gender. Understood otherwise, the body functions as a point of reference, which is used to signify the unspoken privilege granted to those "coherent" bodies that are easily read and identified based on the coherency of their gender presentation and assumed sexed materiality. In other words, coherency is comprehended to reside through the body and the social signifiers that communicate cohesiveness. This coherency is attained partly in contrast to groups of individuals who do not conform to established patterns (Rottnek 4).

As Talia Mae Bettcher notes, gender presentation is "taken as a *sign* of sexed body, taken to *mean* sexed body, taken to *communicate* sexed body" (emphasis in original, 52). Individuals whose gender presentation appears ambiguous, who engage in cross-sex or gender non-conformist expressions and behaviours, are denied the status of full humanity granted to those who experience life in accordance to cisnormativity[46] – the belief that trans bodies and identities are unnatural or less authentic – and who are encompassed within the paradigm of cissexual privilege. Cissexual privilege thus refers to the taken-for-granted ways in which society grants legitimacy to cis people (non-transsexuals) in social and legal spheres.

The denial of full humanity can be seen in the ways that parents and medical personnel attempt to regulate gender variant behaviour and expression through the medical category of Gender Identity Disorder (GID). Canadian mental health professionals (including psychiatrists and psychologists) and social workers – among

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[46] I use 'cisnormativity' to draw attention to those expressions and behaviours that are taken to be natural.

other health care providers – use the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM) as a common nomenclature for the diagnosis of emotional or psychological diseases and illnesses.[47] The GID diagnosis in the DSM complicates our understanding of trans- identities and sex/gender because of the ways in which it situates non-cissexual and non-traditional gender identities as disordered. I return to a more detailed examination of the GID diagnostic criteria below.

The GID diagnosis is also used by medical personnel to authorize access to medical options such as therapy, hormone treatments and surgeries, which the Canadian legal system then employs, in part, as required proof for change of sex designations. Canadian law requires individuals to fit within the definitions and parameters that define its rule. Such definitions and parameters are structured with an unchanging, static narrative of the self in mind. Therefore, legal attempts at changing the biographical narrative of the self, such as a change of sex designation, can prove challenging. In particular, sex designation plays an important role in jurisdictions that define marriage strictly in a heterosexual manner, as between one 'woman' and one 'man'.

In the following section, I outline the historical importance of determining sex designation for marriages in Ontario prior to the passing of the 2005 Bill C-38, the Civil Marriage Act. This federal decision radically altered the discursive landscape of marriage in Canada, and is an example of the intersection that exists between trans and gay rights. Considering the conflation of gender, sex and sexuality that often occurs in discussions of marriage and civil rights, the definition of civil marriage must take into account both issues of queer and trans rights. I do not wish to draw an arbitrary line between queer

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[47] In Europe, the World Health Organization's International Classification of Diseases (ICD-10) is more commonly used. Under section F64 - Gender identity disorders, the ICD retains the term 'transsexualism' (F64.0) and 'Gender identity disorder of childhood' (F64.2) (ICD-10, ch. 5, F-64).

and trans activism – in fact, I maintain that there is significant crossover between the two categories and a strict binary delineation is unattainable, and perhaps even undesirable.

Legal Implications of Defining "Sex": Marriage Prior to Bill C-38, a Case Study

Transsexual individuals are implicated in jurisdictions where civil marriage is conceptualized as legal only between heterosexual partners (defined by a sex designation at the time of birth). I make use of the historical debates within Canada surrounding same-sex marriage rights to highlight how transsexual individuals are influenced by legal discourses concerned with a definition of marriage. The issue of marriage serves as an accessible example of the consequences legal approaches to sex/gender have for Canadians – including trans Canadians – as civil marriage laws are applicable to anyone who lives, or decides to get married, in Canada (Citizenship and Immigration n. p.). Through an examination of marriage prior to Bill C-38, it is possible to explore the ongoing Canadian approach to both queer and trans rights.

Let us then suspend for the moment the current Canadian legal recognition for marriage as between two persons, regardless of their sexual orientation or birth-sex designation. If the courts understand sex as an unchanging biological fact, marriage may be denied to a transsexual individual based on the makeup of the relationship. If, for example, the partnership is considered a same-sex union prior to a partner's transition, a marriage license may be denied; however, if the post-opt sex of the transsexual partner is accepted as their legal sex, wherein the new legal sex of the transsexual would not result in a same-sex union, a court might find such a union to be legally recognizable. If a partner in a marriage makes the decision to transition – thereby causing the status of the relationship to change from different-sex to same-sex – the marriage might be void for

the purposes of divorce or family law. Therefore, how the courts approach the issue of civil marriage and how they legally define the sex and gender of a trans- individual – i.e. whether a post-opt transsexual is recognized in their new sex/gender – will impact whether a previous marriage is annulled, or a future marriage is recognized by the government. This recognition or denial also impacts the legal benefits accorded to the individual, to the couple or, in the case of separation.

In Canada, sections VI. 91 and 92 of *the Constitution Act, 1867 to 1982*, configure the distribution of legislative powers. The Act designates s. 91(26) Marriage and Divorce under the exclusive legislative authority of parliament, with s. 92(12) Solemnization of Marriage under the exclusive powers of provincial legislatures. Therefore, under the Constitution of Canada, the legal capacity for civil marriage falls under the rule of the federal government.

Under Prime Minister Jean Chrétien, the Canadian government referred draft marriage legislation[48] to the Supreme Court of Canada in July 2003. The draft bill proposed a definition of marriage not reliant on opposite-sex designations and addressed the issue of religious freedom. The government requested that the Court consider whether:

> (1) the draft bill fell within Parliament's exclusive legislative authority; (2) the bill's extension of the capacity to marry to persons of the same sex was consistent with the Charter; and (3) the Charter's freedom of religion guarantee shielded religious officials from being forced to perform same-sex marriages contrary to their religious beliefs (Hurley, n. p.).[49]

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[48] Proposal for an Act respecting certain aspects of legal capacity for marriage for civil purposes, Order in Council P.C. 2003-1055, Preamble, ss.1,2. ("Proposed Act").

[49] Later, an additional fourth question was put to the Supreme Court: "4. Is the opposite-sex requirement for marriage for civil purposes, as established by the common law and set out for Québec in section 5 of the *Federal Law–Civil Law Harmonization Act, No. 1*, consistent with the *Canadian Charter of Rights and Freedoms*? If not, in what particular or particulars and to what extent?" The Court exercised its discretion to not to answer Question 4 (Reference re Same-Sex Marriage, [2004] 3 S.C.R. 698, 2004 SCC 79).

The 9 December 2004 decision of the Supreme Court of Canada (Re Same-Sex Marriage) upheld that the draft bill was within Parliament's exclusive legislative authority over legal capacity for civil marriage, that same-sex marriage was consistent with the *Canadian Charter of Rights and Freedoms*, and that religious freedom for religious officials would not be compromised under subsection 2(*a*) of the Charter (Hurley n. p.).

Bill C-38, or the Civil Marriage Act (based on the 2004 draft bill), was first read in the House of Commons on 1 February 2005, and reached Royal Assent on 20 July as Chapter 33 of the Statues of Canada for 2005. The bill codifies, for the first time, a definition of marriage in Canadian law.[50] It expands on traditional common-law understanding of civil marriage reliant on heterosexual partnering, defining civil marriage as "'the lawful union of two persons to the exclusion of all others,' thus extending civil marriage to conjugal couples of the same sex" (Hurley n. p.).

Prior to the Civil Marriage Act and without a statutory definition of marriage, the two leading cases in Canadian law (prior to 2001[51]) concerned with same-sex marriage turned to British precedents. The first is the 1866 British ruling in *Hyde v. Hyde and Woodmansee,* which concerned whether a man could obtain a divorce from his wife in

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[50] As well, "the *Civil Marriage Act*, S.C 2005, c. 33, amended s. 2(1) of the *Divorce Act* to redefine spouse as 'either of two persons who are married to each other' rather than 'either of a man or woman who are married to each other'. It also amended several other federal statutes. In February 2005, the Ontario legislature passed the *Spousal Relationships Statue Law Amendment Act, 2005*. It amended numerous provincial statues in light of the recognition of same-sex marriages" (Hovius and Maur 95, en. 4).

[51] Between 2001 and 2005, 11 of 12 provincial and territorial courts to have considered Charter challenges dealing with same-sex marriage reworked the traditional common-law definition of marriage between opposite-sex persons. In July 2002, the Ontario Superior Court of Justice (Divisional Court) found that the [then] common law definition of marriage defined between one 'man' and one 'woman', was in violation of section 15 of the *Canadian Charter of Rights and Freedoms*. The 10 June 2003 unanimous decision of the Court of Appeal for Ontario in *Halpern v. Canada*, [2003] O.J. No. 2268, upheld the Divisional Court's decision (*Halpern* v. *Canada (Attorney General)* (2003), 36 R.F.L. (5th) 127 (Ont. C.A.), affirming [2002] O.J. No. 2714 (Q.L.), (Ont. Sup. Ct. Justice (Div. Ct.)). Legislators in British Columbia, Québec, Saskatchewan, Manitoba, Newfoundland and Labrador, Yukon, New Brunswick and Nova Scotia, also enacted a wide range of legislative measures relating to same-sex entitlements prior to the passing of Bill C-38.

England on the grounds of adultery. The petitioner and respondent were married in a Mormon ceremony in Salt Lake City in 1853, where polygamy was part of the Mormon doctrine. After three years the husband left Utah, and was subsequently excommunicated by the Church, thereby allowing the wife to remarry. The petitioner's request in the English Court for a dissolution of the marriage based on adultery was denied on the grounds that the marriage had taken place in a country where polygamous relationships were accepted, but which was not accepted as a valid marriage under English (Christian) matrimonial Courts (Mossman 85; *Hyde* v. *Hyde & Woodmansee* (1866), L.R. 1 P&D 130). In relation to polygamy, Lord Penzance of the English Court defined the institution of marriage "as understood in Christendom, ... as the voluntary union for life of one man and one woman, to the exclusion of all others" (Hurley n. p.). The Court's decision in *Hyde*, in particular Lord Penzance's statement, has been cited as the precedent for the requirement of heterosexuality for a valid marriage in Canada (Hurley n. p.).

The second British precedent is 1970 British decision in *Corbett* v. *Corbett,* which concerned the validity of a marriage between April Corbett, a male-to-female (MtF) woman, and her husband Arthur Corbett. Arthur Corbett sought to annul the marriage on the grounds of "non-consummation" (Mossman 110). The court decided that the marriage was void because April Corbett was categorized as a man for the purpose of marriage, based on a three-point test using chromosomal, gonadal and genital features at the time of birth. This view of sex as fixed at birth removed the possibility of a change of designation through alternations by medical and surgical means (Whittle 1998, 49).[52] The court

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[52] Stephen Whittle problematizes the case further by noting that the judgment of Ormrod LJ "mixed the notions of 'male and female' with those of 'man and woman'. For example, [Ormrod LJ] states in conclusion... 'the respondent is not a woman for the purposes of marriage but is a biological male and has been so since birth' (*Corbett* at 49)" (Whittle 1998, 50).

determined that as marriage is a heterosexual union, biological sex is an "essential determinant of the relationship called marriage" *(Corbett* v. *Corbett (otherwise Ashley)*, [1970] 2 All E.R. 33, p. 48 (P.D.A.)). The court's decision in *Corbett v. Corbett* has been followed until recently in numerous common law jurisdictions, in South Africa, the United States, and Europe, among others.[53] As Greenberg points out, "[l]egal institutions must explore whether the law should continue to rely on traditional sex criteria such as chromosomes, genitalia, and gonads to define a person's legal sex or whether these factors should be subordinated to self-identified sex" (Greenberg 63).[54]

In two Canadian cases, *C.(L.)* v. *C.(C.)* (1992) and *B. v. A.* (1990), Ontario courts following the doctrine in *Corbett v. Corbett* (1970), ruled that FtM transsexuals were held to not be spouses/husbands for the purposes of marriage and family law, if hysterectomy and bilateral mastectomy were the only SRS procedures undertaken (Whittle 1996).[55] In *C.(L.)* v. *C.(C.)* (1992), 10 O.R. (3d) 254, a woman applied for her marriage to be annulled on the grounds that the applicant had married her partner after she had undergone hormonal treatment, a hysterectomy and mastectomy, but had not followed through with the planned genital reconstructive surgery as promised to the applicant. "The courts held that the parties were both female at the time of the marriage, so that it was a nullity" (Mossman 112-113).

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53 In recent years, courts in Australia have rejected the English decision in *Corbett v. Corbett* ([1970]2 WLR 1306). The Australian courts "have rejected the notion that 'sex is determined at birth' in favour of a story of 'psychological and anatomical harmony' whereby transsexual persons who have undergone sex reassignment surgery have been granted legal recognition" (Sharpe 1998, 28).

54 An alternative, but relevant question to ask concerns the very necessity of sex designation requirements on legal documentations.

55 The applicants were held to not be spouses/husbands for the purposes of marriage and family, though the surgeries undertaken qualified them as men for other purposes, such as legal name changes (Whittle 1998, 52).

In *B. v. A.* (1990), an Ontario court refused to grant a motion of spousal support even though the parties had lived together for 20 years. The court deemed that although the female-to-male partner had changed birth records from female to male, the requirements for surgery of the Registrar General were not the same in deciding if the relationship was of husband and wife (Whittle 1996, n. p.). The court stated that surgery must be irreversible for the purposes of financial support under the Family Law Act. As the applicant had not had what the court defined to be "radical and irreversible surgical intervention with all the fundamental reproductive organs, more than their simple removal, and independent of exterior continuing circumstances" (*B.* v. *A.* (1990), 29 R.F.L. (3d) 258 (Ont. Master)), the court expressed concern with the potential for a reversal in gender expression (to female) should B cease taking hormones. "Since B's genitalia have not been altered and B would revert to a female appearance without continuing hormone therapy, B is not a 'man' within the meaning of the *Family Law Act*, 1986" (*B.* v. *A.* (1990), 29 R.F.L. (3d) 258 (Ont. Master)). Here, the absence or presence of phalloplastic surgery is upheld to determine the sex designation requirement for understanding a conjugal relationship between a (otherwise coherent) man and woman.

This ruling is reflective of traditional jurisprudence that requires individuals to be classified into a binary categorization on the basis of sex. Court rulings and legislation that makes use of the term sex (male/female) rely on an implicit assumption that only two biological sexes exist. Stemming from this is also the assumption that individuals fit neatly into one or the other of these two categories.[56] However, a variety of factors –

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[56] John Money and Patricia Tucker write: "The assumption is that there are two separate roads, one leading from XY chromosomes at conception to manhood, the other from XX chromosomes at conception to womanhood. The fact is that there are not two roads, but one road with a number of forks that turn in the

biological, social and self-proclaimed – must be considered and contribute to the process of defining an individual as male or female in legal documents.[57] Sex reassignment surgery often plays a role as a requirement for gender recognition for those requesting a change of sex designation on legal documents. As the ruling in *B. v. A.* (1990) indicates, however, even within legal discourses what qualifies as sex reassignment surgery remains contested. In Ontario, documented proof of sex reassignment surgery is required for the Registrar General to make alterations to birth certificates (and subsequent legal documentations). Below, I examine the requirements for such amendment requests as set out under the Ontario *Vital Statics Act* (1990).

Obtaining Change of Sex Designation: The Ontario *Vital Statistics Act*

Ontario's *Vital Statistics Act* (R.S.O. 1990, c. V. 4, s. 36), allows for amendments to be made on the registration of birth regarding the sex designation. Section 36 (1) – "Changes Resulting from Transsexual Surgery" (Appendix A) – of the Act notes:

> Where the anatomical sex structure of a person is changed to a sex other than that which appears on the registration of birth, the person may apply to the Registrar General to have the designation of sex on the registration of birth changed so that the designation will be consistent with the results of the transsexual surgery.

Subsection (2) notes that an application made under subsection (1) must be accompanied by three requirements. Clause 2 (a) requires a certificate signed by a medical practitioner

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male or female direction. Most of us turn in the same direction at each fork" (quoted in Greenberg 55 - original in: Sexual Signatures: On being a man or a woman Boston: Little, Brown, 1975, 6).

[57] Some of the biological and social factors include chromosomal sex, gonadal sex, external genitalia or morphologic sex, internal morphologic sex, phenotype sex, assigned sex, and self-identified sex. For many people, these factors are all congruent, therefore the assumption that the terms 'male' and 'female' are fixed and unambiguous prevails even when medical literature has shown this to be false. Melanie Blackless et al. conducted a recent survey of the medical literature from the second half of the twentieth century. The authors estimate that approximately 2 percent of live births may be intersex, with individuals displaying either ambiguous or non-congruent sex features, or who otherwise deviate from the sexually dimorphic norm.

who performed the "transsexual surgery", certifying their role, and the results of the surgery for the designation of sex change on the registration of birth of the applicant. Clause 2 (b) calls for a certificate of a medical practitioner who did not perform the transsexual surgery certifying that he or she has examined the applicant and that the results of the examination substantiate that transsexual surgery was performed upon the applicant. The secondary medical practitioner must also indicate that due to the results of the surgery, the designation of the sex of the applicant should be changed on the registration of birth of the applicant. Finally, under clause 2 (c), evidence supporting the identity of the applicant must be provided to the Registrar General *(Vital Statistics Act* (R.S.O. 1990, c. V. 4, s. 36)).[58]

The Act notes that birth certificates issued after notation under this section will be issued "as if the original registration of birth had been made showing the [changed] designation of sex" (*Vital Statistics Act* (R.S.O. 1990, c. V. 4, s. 36)). The reissued birth certificate can then be used to apply for amendments to be made to other legal documents, such as an application to change a legal name, or to attain other government issued identifications such as an Ontario Health Insurance Policy (OHIP) card[59].

Though the *Vital Statistics Act* (1990) adopts recognition for post-operative individuals, it remains unclear what constitutes transsexual surgery under the Act. Transsexual surgery may or may not include hormone therapy, the removal of internal

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[58] The Act also outlines alternate medical evidence that can be submitted in the event that it is not possible to obtain the medical certificate referred to in clause 2 (a) or (b).

[59] Changes to the sex designation on official health-related documents, such as OHIP cards, continue to impact the type of health care provided to the patient. Bauer et al. note that billing systems in jurisdictions such as Ontario are often "set up with an assumption of concordance between listed sex and body parts and allow billing for sex-specific procedures only to individuals of that designated sex" (Bauer et al. 2009, 355).

reproductive organs (hysterectomy and ovariectomy[60]), mastectomy[61], phalloplasty[62] or metoidoioplasty[63], among other surgeries for trans men. Similarly, transsexual surgery may or may not include hormone therapy, orchiectomy[64], or vaginoplasty[65], among other surgeries for trans women. As such, the 'sex reassignment surgery' requirement may cause inconsistency and unpredictability in its application (Tobin 415).

Additionally, the medical certificates required under the *Vital Statistics Act* (R.S.O. 1990, c. V. 4, s. 36) are reflective of the reliance on medical expertise to give recognition and validity to trans bodies. As Sally Hines writes, "[o]ne way of gaining social recognition is through the sanction of the 'expert'. Thus, the construction of a transgender identity frequently relies upon medical intervention" (2007, 58). The overt reliance on a medical model of care, with expert knowledge and approval, depends on a cissexual system that conceives of 'gender dysphoria' as problematic and in need of the appropriate 'treatment'. Hines continues by noting, "A diagnosis of 'gender dysphoria' enables access to surgery, which is understood within medical discourse and practice as the appropriate 'treatment' for 'gender dysphoria'" (2007, 169). Surgery can then be used to apply for legal recognition of the individual under a new sex designation. It is this

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60 Hysterectomy is the surgical removal of the uterus, while ovariectomy is the surgical removal of the ovaries.

61 Mastectomy is the surgical removal of the breasts.

62 Phalloplasty refers to surgical techniques for penile reconstruction. There does not exist one single ideal surgical technique for phalloplasty, and the results may vary greatly (Sohn and Boniski 1201-1208).

63 Metoidoioplasty involves the creation of a neopenis from the clitoris through the effects of androgen hormone treatment. The enlarged clitoris is released from its position and can serve as a penis. Sohn and Boniski note that metoidoioplasty remains "the method of choice in FM-TS patients who are in doubt about their need for phalloplasty" (1201).

64 Orchiectomy is the removal of the testes.

65 The surgical procedure(s) to create the neovaginal cavity outlined under the term vaginoplasty can involve the amputation of the penis, the creation of the neovaginal cavity, lining of this cavity, the reconstruction of the urethral meatus to control the direction of the urinary stream, and the construction of labia and clitoris.

"seizing" on the body, as Butler (2001) argues, that aims to bring the inconceivable into alignment with a socially coherent, normative vision of gender.

As my examination of the historical influence of sex designation upon civil marriage in Canada reveals, trans and queer issues often overlap and inform each other. This overlap is also apparent in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) published by the American Psychiatric Association (APA). Although the Board of Trustees of the APA voted, in 1973, to delete homosexuality as a mental disorder from the seventh printing of the DSM-II (K. Wilson 1998, n. p.), both sexual orientation and gender identity share similar elements, such as social stigma, perceptions of distress, disadvantage and disability. I will first briefly outline the removal of homosexuality as a disorder before moving onto my examination of the problematic nature of the Gender Identity Disorder diagnosis in the DSM. Prior to its removal, homosexuality was seen as being an inherent impairment. As I argue below, the GID diagnosis raises similar concerns previously leveled against the diagnosis of homosexuality.

The DSM: From Homosexuality to Gender Identity Disorder

By the mid-twentieth century, homosexuality was seen as innately pathological, with distress and impairment inherent within the classification itself. Otherwise stated, homosexuality itself was seen as an impairment causing distress, instead of the understanding that an intolerant social structure causes the impairment and distress experienced by homosexuals. "This conclusion followed two basic threads: that deviance from what was presumed biologically natural constituted disability, and that homosexuality was inevitably associated with other pathologies" (K. Wilson 1998, n. p.).

The deletion of homosexuality in 1973 presents the rejection of an inherent distress and impairment associated with being homosexual. However, the same issues continue to plague transvestic fetishism (which I am unable to explore here but which is defined as distress or impairment felt by heterosexual males based on sexual arousal from cross-dressing[66]) and gender identity disorder. With the DSM-IV (1994), the APA decided to merge the previous diagnosis (in DSM-III-R APA, 1987) of Transsexualism with the diagnosis of Gender Identity Disorder of Childhood (GIDC) and Gender Identity Disorder of Adolescent or Adulthood, Nontranssexual Type (GIDAANT) into one diagnosis: Gender Identity Disorder (GID), with specifications as to "in children" or "in adolescents or adults" (Pleak 35; K. Wilson 1998, n. p.).

Katharine K. Wilson notes that due to broad criticism of psychiatric classification (refer to Thomas Szasz 1961) the definition of mental disorder in the DSM-IV (APA 1994, xxi) placed distress and impairment[67] central, with the addition of a clinical significance criterion (Table 1, Criterion D) added to the diagnostic criteria for all Sexual and Gender Identity disorders. The DSM-IV outlines the definition of "mental disorder" as follows:

> In the DSM-IV, each of the mental disorders is conceptualized as a clinically significant behavior or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom (APA 1994).

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66 Refer to Ray Blanchard (2010).

67 It remains that specific definitions of distress and impairment (in one or more important areas of functioning) are not provided in the diagnosis. However, relationship difficulties and impaired function at school or work are listed as examples of distress and disability in the supporting text (DSM-TV-TR 577). Katherine K. Wilson notes that no reference is made here to the role of societal prejudice as the cause of such distress (K. Wilson n. p.).

The formulation of the GID diagnosis, places significant emphasis on gender identity and expression that differs from assigned birth sex as inherently disordered. This pathologization of nonconformity to assigned birth sex disregards the definition of mental disorder associated with distress and impairment. The focus on gender nonconformity, particularly identification with the "other sex", is problematic as it does not take into consideration the happiness of the individual with that identification. For example, many adults are capable of living gender-unconventional lives without experiencing a significant sense of unhappiness or distress. The GID diagnosis assumes that gender dysphoria is symptomatic of mental illness, that femininity expressed by males and masculinity expressed by females is pathological. However, 'deviant' gender behaviour should not necessarily be conflated with a distressed mode of being dysphoric. As well, distress and impairment experienced can be the result of stigma, or social prejudice, which is not made clear in the diagnosis.

I believe the clinical approach to gender identity disorder functions with several implicit assumptions. First, there is an understanding of gender that is, for the most part, static. The adolescent or adult desire to physically transform from one sex to the other, according to the GID diagnosis, takes for granted the underlying assumption that one gendered mode of being (feminine) corresponds, naturally, to only one sexed body (the female). This desire to be "the opposite sex" presupposes a mutually exclusive definition of what each sex is like (Eichler 285). Alongside an understanding of gendered behaviour as fixed is also a perception of the body as fixed, more or less, after puberty. Our bodies continue to change, however, particularly in response to our behaviours: "[n]ot only do [our bodies] generate behaviors, but they in turn are generated by behaviors" (Fausto-

Sterling 56). We must stop thinking of the body as something that is unchanging, and as merely the base on which cultural signifiers work to reveal an assumed materiality. I now turn to my analysis of the DSM-IV-TR's diagnostics criteria for Gender Identity Disorder.

The GID Diagnostic Criteria

The GID diagnosis retains ambivalence as it provides us with both negative and positive readings. To outline the dual nature of the diagnosis, I first begin with an analysis of the problematic components of the criteria and then move on to discuss how the diagnosis functions to facilitate strategic access to medical care for some trans patients. Criterion A – a strong and persistent cross-gender identification, outlined in Table 1 – highlights the desire to be treated as, or the "frequent passing as," the affirmed gender as pathological. Under this criterion, gender expressions and behaviours that are taken to be natural for cissexual children, adolescents and adults are stigmatized when expressed by individuals who transgress their natal gender/sex designation. Similarly, Criterion B defines the distress of gender dysphoria as discomfort or inappropriateness in the gender of assigned sex. The diagnostic criterion for children, in particular, obfuscates clinically significant distress by emphasizing non-conforming behaviour to the gender stereotypes of the assigned birth sex. Children need only to meet four of the five "disturbed'" manifestations. The child's expressed "desire to be, or the insistence that he or she is, the other sex" – evidence of gender dysphoria – is not a necessary requirement for a GID diagnosis to be made. For children, both Criteria A and B overwhelmingly stress masculine or feminine expression in clothing, play, games, toys, and fantasy as symptoms of mental 'disturbance'. Therefore, childhood play is perceived as disordered

if it transgresses activities associated with assigned birth sex stereotypes. As Eve Kosofsky Sedgwick (1991) notes, in the diagnosis of GID in children, gender is *re*-naturalized, with differential diagnostic criteria offered for boys and girls (20-21). For example, Criterion A (2) outlines a "preference for cross-dressing or simulating female attire" in boys, indicating that this preference can be sporadic or occasional (DSM-IV-TR 581). As Criterion A (2) pertains to girls, however, it requires the "insistence [of] wearing *only* stereotypical masculine clothing," indicating that such actions are more consistent (emphasis added, DSM-IV-TR 581).

In discussing children with gender dysphoria, Richard R. Pleak notes that most children diagnosed with GID do not grow up to be transsexual (35), which raises the question why a diagnosis is needed for non-transsexual gender dysphoric children.[68] Pleak goes on to argue that parents who bring their children to mental health practitioners for treatment "often make the assumption that their child is prehomosexual, and believe or hope that alteration of the child's gender-role behavior will diminish the likelihood of later homosexuality" (43). Some therapists, such as Zucker[69] (Zucker and Bradley 1995) do not claim that treatment alters later sexual orientation, but they justify treatment on the grounds of "social ostracism and peer rejection the child may endure if cross-gender behavior persists, especially as the child enters school and early sex-segregated play

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[68] Eve Kosofsky Sedgwick's 1991 article, How to Bring Your Kids Up Gay, addresses the problematic works of Richard Green and Richard C. Friedman, which focus on the psychopathology of effeminate boys. As Sedgwick argues, "The reason effeminate boys turn out gay, according to [these] accounts, is that other men don't validate them as masculine" (1991, 22). According to Sedgwick, the theoretical move of distinguishing gender from sexuality has resulted in a denaturalization of "sexual object-choice" and the re-naturalization and "enforcement of gender assignment" in what she calls the new psychiatry of gay acceptance. Sedgwick argues that "the presiding asymmetry of value assignment between hetero and homo goes unchallenged everywhere" and that associated therapeutic strategies and institutions which aim to "prevent the development of gay people" support the wish that gay people *not exist* (23).

[69] Kenneth J. Zucker is with the Centre for Addiction and Mental Health (CAMH), in Toronto, and is also the chair of the DSM-V workgroup on Sexual and Gender Identity Disorders.

ensues" (Pleak 44). Pleak advises that therapy with gender-dysphoric adolescents should focus on or be directed towards "forestalling or preventing inappropriate, premature, and potentially harmful behavior by the adolescent, such as suicidality, self-castration, taking street or mail-order hormones, and sharing needles to inject hormones" (Pleak 47). At the same time, other mental health care providers, such as psychologists George Rekers and Mark Kilgus, actively promote "treatment" practices that praise and reward the child in response to "appropriate sex-typed play and behavior mannerism" (Rekers 281) while ignoring or redirecting cross-gender behaviour.[70]

Table 1. *DSM-IV-TR* Diagnostic Criteria for Gender Identity Disorder

A. A strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex). In Children, the disturbance is manifested by four (or more) of the following: (1) repeatedly stated desire to be, or insistence that he or she is, the other sex (2) in boys, preference for cross-dressing or simulating female attire; in girls, insistence on wearing only stereotypical masculine clothing (3) strong and persistent preferences for cross-sex role in make-believe play or persistent fantasies of being the other sex (4) intense desire to participate in the stereotypical games and pastimes of the other sex (5) strong preference for playmates of the other sex In adolescents and adults, the disturbance is manifested by symptoms such as a stated desire to be the other sex, frequent passing as the other sex, desire to live or be treated as the other sex, or the conviction that he or she has the typical feelings and reactions of the other sex.
B. Persistent discomfort with his or her sex or a sense of inappropriateness in the gender role of that sex. In children, the disturbance is manifested by any of the following: in boys, assertion that his penis or testes are disgusting or will disappear or assertion that it

[70] In their discussion of differential diagnosis and rationale for the treatment of GID and transvestism, Rekers and Kilgus write: "[I]t is not inappropriate for a given society, such as American society, to teach girls to clothe their upper torso in public and to prohibit males from regularly wearing skirts and dresses in public; this form of arbitrary assignment of sex-typed clothing does not, in fact, necessarily impose any unfair restriction upon individual development... Therefore, a boy who prefers wearing dresses, lipstick, and eyeliner, or the boy who puts on his mother's apron to wash the dishes while fantasizing that he is a woman, is exhibiting problematic behavior in need of intervention for the child's own adjustment" (Rekers and Kilgus 266).

would be better to not have a penis, or aversion toward rough-and-tumble play and rejection of male stereotypical toys, games, and activities; in girls, rejection of urinating in a sitting position, assertion that she has or will grow a penis, or assertion that she does not want to grow breasts or menstruate, or marked aversion toward normative feminine clothing. In adolescents and adults, the disturbance is manifested by symptoms such as preoccupation with getting rid of primary and secondary sex characteristics (e.g., request for hormones, surgery, or other procedures to physically alter sexual characteristics to simulate the other sex) or belief that he or she was born in the wrong sex.

C. The disturbance is not concurrent with a physical intersex condition.

D. The disturbance causes clinically significant distress or impairment in social, occupational or other important areas of functioning.

Specify if (for sexually mature individuals) Sexually Attracted to Males, ... Females, ... Both, ... Neither.

Adapted from APA, 2000, 581

Criterion C of the diagnosis, which functions to exclude those with physical intersex conditions, is ignored under the category Gender Identity Disorder Not Otherwise Specified (302.6), wherein intersex conditions and 'accompanying gender dysphoria' (First et al. 313) are listed as examples. Included here are hormonal disorders such as *partial androgen insensitivity syndrome* and *congenital adrenal hyperplasia. Partial androgen insensitivity syndrome* affects individuals born with XY chromosomes and normally functioning testes, but who have a receptor defect causing their bodies to be unable to process the androgens produced by the testes. *Congenital adrenal hyperplasia* affects individuals with XX chromosomes, female internal structures, and ovaries, but who were exposed to an abundance of androgen production in utero, resulting in more masculinized external appearance (Greenberg 59-60). It is unclear how intersex conditions which would otherwise exclude diagnosis based on the very principal criterion of GID, can function for otherwise not classifiable gender identity disorders.

Criterion D, which outlines the requirements for clinically significant distress or impairment as established in the definition of mental disorder, fails to distinguish the source of such distress and/or impairment. It is unclear whether the distress and/or impairment arise from an intrinsic psychological impairment of gender dysphoria or is caused by external factors such as prejudice and social intolerance. The "associated descriptive features" for the diagnosis lists isolation, low self-esteem, and relationship difficulties as examples of distress and disability (APA 2000, 577). Prostitution, self-treatment with hormones or self-performed surgeries, increased risks for HIV infection, suicide attempts and substance abuse are also described as associated features of GID. In other words, it is not made clear in the DSM that such actions are by definition impairments resulting *from* gender dysphoria rather than as the consequence of social discrimination against gender variant individuals. Judith Butler makes a similar argument, noting diagnosis does not take into consideration the gender norms it presumes to be fixed and "whether these norms produce distress and discomfort, whether they impede one's ability to function, or whether they generate sources of suffering for some people or for many people" (2004, 95).

It is for these reasons that the status of the DSM diagnosis of Gender Identity Disorder is questioned by activists, theorists (see Judith Butler 2006), and even among professionals (see Heino F. L. Meyer-Bahlburg 2010). On the other side of the debate is the argument that maintaining the diagnosis functions to facilitate access – for adolescents and adults – to medical and surgical technologies required for transitioning. As well, the diagnosis provides the certification for medical coverage by governmental or third party insurance groups by establishing SRS as medically necessary. Alternatively,

some activist psychiatrists and theorists, such as Kelley Winters[71] and Judith Butler, argue against pathologizing or labeling atypical gender identity and behaviour. As Butler argues in *Undoing Gender* (2004), "even if the diagnosis is approached as an instrument or vehicle for accomplishing the end goal of transitioning, the diagnosis can still (a) instill a sense of mental disorder on those whom it diagnoses, (b) entrench the power of the diagnosis to conceptualize transsexuality as a pathology, and (c) be used as a rationale by those who are in well-funded research institutes whose aim is to keep transsexuality within the sphere of mental pathology" (83). Therefore, we can note that the diagnosis can be used strategically as a way of gaining funding for procedures and for alleviating suffering, while at the same time, the diagnosis can intensify the very suffering that requires alleviation (100). Richard R. Pleak writes: "One compromise would be to eliminate the GID diagnosis as it relates to children, and retain it only for those transgendered adolescents and adults who wish to alter their bodies and are requesting therapy, hormones, and/or surgery" (Pleak 37). Alternatively, another compromise may be to narrow the definition to dysphoria and to remove the designation disorder from the diagnosis.

While Gender Identity Disorder's role within the DSM is to provide mental health care professionals with diagnostic tools to aid in their treatment of patients, the diagnosis has far reaching influence apparent in the ways it influences broader discourses regarding gender dysphoria. Cissexual policy makers and service providers must become more aware of the imbedded assumptions within the diagnostic approach to gender identity and expression. An approach to gender variance as pathology is not sufficient. As the authors

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[71] Kelley Winters is the founder of GID Reform Advocates and an Advisory Board Member for the Matthew Shepard Foundation and TransYouth Family Advocates.

of the Trans PULSE Project indicate, we must continue to examine the systematic nature of trans marginalization in broader cultural and political contexts, and aim to provide answers that move beyond the attribution of marginalization as just a consequence of transphobia.

Trans PULSE Project

The Trans PULSE Project – funded in part by the Canadian Institute of Health Research[72] – is a comprehensive community-based research project aimed at documenting the lived experiences of trans people in Ontario. The objectives of the project are to examine the social determinants of health and basic healthcare of the trans community, and how social exclusion affects health. The project is partnered with Wilfred Laurier University and The University of Western Ontario, The Ontario HIV Treatment Network, Sherbourne Health Centre, Rainbow Health Ontario, the 519 Community Centre and TGStation.com.

The Trans PULSE Project is organized in three phases. Phase I involved qualitative research and community soundings (meetings), held in Toronto, Ottawa and Guelph in summer 2006 to discover what health issues were of concern to trans people in Ontario. Overall, 89 participants took part in the seven soundings that took place in trans-only spaces (the meetings were facilitated by trans investigators from the research team). In addition to the community soundings, an online sounding for peer and professional

[72] The project's development stage was funded by the Wellesley Institute and The Ontario HIV Treatment Network (OHTN). In February 2007, the Canadian Institute of Health Research awarded the Trans PULSE Project $288,400 for continued research over the next three years.

service providers[73] serving trans clients or patients in Ontario was also held. Of the 63 providers who participated, 59% provided services in the Greater Toronto Area and were from a variety of professional backgrounds. The authors of the Trans PULSE Project note that, overall, service providers felt that their formal training was inadequate for the work they do:

> 43% reported they had no formal training about trans people and their needs, 22% had training that was 'not comprehensive,' and an additional 21% reported their training was 'somewhat comprehensive.' In lieu of training, some providers reported that they had learned much from their trans clients directly… (Bauer et al. 2007, 10).

As well, the peer and professional service provider soundings revealed that providers did not always have the information needed to best serve their patients or clients, and often experienced difficulty in finding services to meet their client's needs. "Specialized services for trans youth of colour or disabled trans clients or those with extensive health needs were cited as lacking. Referral networks for all types of services outside of Toronto were sparse and not stable" (Bauer et al. 2007, 11).

In their discussion of the results from Phase I of the project, published in the September/October 2009 issue of *Journal of the Association of Nurses in AIDS Care*, Bauer et al. theorize a framework for how erasure functions in relation to interactions with health care systems. They outline two key sites of erasure: informational erasure and institutional erasure. Though phase I of the project covered a broad range of topics, the focus remained on experiences within health care systems. The authors discovered that informational erasure exists in both the lack of knowledge regarding trans people and

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[73] Peer and professional service providers who participated in the soundings included health care personnel, mental health care and counseling providers, legal service providers, and those involved in community development and formal or informal support services (Bauer at al. 2007).

trans issues, and in assuming that such knowledge does not exist at all.[74] Institutional erasure functions through the lack of health, education or hiring policies that accommodate trans bodies, and issues, "including the lack of knowledge that such policies are even necessary" (Bauer et al. 2009, 354).[75] Such processes of erasure contribute to an overall sense of social exclusion and community invisibility, such that trans people are perceived as isolated cases rather than members of a community. The authors attribute cisnormativity as underlying all these processes of erasure.

Bauer et al. also point out that for mental health care professionals, the primary source of information on trans people exists in the Gender Identity Disorder diagnosis of the DSM. The authors note, however, that a lack of understanding still remains in the relation between mental health and gender identity: "although research results have shown that transsexual people are no more likely to suffer from psychopathology than cissexual people … providers may perceive unrelated mental health issues to stem from a person's gender identity" (Bauer et al. 2009, 352). The authors note that care providers are, at times, inclined to link what may be unrelated issues, or to discount an issue due to a mixing of information presented to them. "This erasure reflects the priorities, biases, and oversights of writers and publishers who function in a cisnormative system, one in

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[74] Bauer et al.'s findings here reflect Viviane K. Namaste's findings gathered in the summer of 1995. Namaste notes that "the transgendered people [she] interviewed stated that they did not receive sufficient information from the Clarke GIC about transsexuality, hormones, and how transition would affect their lived" (213).

[75] The systemic unpreparedness of health care providers for addressing trans needs is seen in the disparity between estimated number of trans individuals and the reality of trans persons in Ontario. Bauer et al note, "Given oft-cited estimates from the Netherlands of 1 in 30,400 born females and 1 in 11,900 born males being transsexual… there would be approximately 615 such people in Ontario, including children and infants. Although actual numbers are unknown, one publically funded community health centre in Toronto, which is mandated to provide primary health care services to LGBT communities, currently has more trans clients than should exist in the entire province, given these estimates. Moreover, this agency serves a local catchment area, and many trans people in Toronto (and all trans people in the remainder of the province) do not receive health care there" (Bauer et al. 2009, 354).

which people are assumed to be cissexual" (Bauer et al. 2009, 353). When information has been produced and incorporated into health care protocols, educational curricula, etc., gender identity is often conflated with sexual orientation.

Phase II of the project was launched in November 2007 with data collection begun in May 2009. This phase draws on the findings from Phase I to inform a comprehensive survey aimed at 1000 trans people in Ontario age 16 and older (Bauer et al., June 2009). Instead of relying on sex reassignment surgery as the defining criteria for survey participants, the Trans PULSE research team is adopting a broad definition of what it means to be trans with the intention to include a full range of identities, such as: transgender, transsexual, two-spirited trans, MtF, FtM, trans man, trans woman, gender queer, bi-gendered, t-girl, boi, as well as those who have transitioned and identify as women or men (Trans PULSE n. p.).

Phase II's survey[76] employs a respondent-driven sampling (RDS) method – in which respondents recruit other participants from their network[77] – in order to generate accurate population-based statistics that include individuals who are not in clinical care, or who do not participate in specific trans community organizations or venues. The survey includes questions about healthcare access, including primary care, emergency care, mental healthcare for both trans-related and non-trans-related issues, HIV/AIDS related healthcare, as well as questions regarding employment, income, housing, social support, emotional wellbeing, sexual health, substance use and more (Zanin n. p.). The

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[76] The survey, which is conceived of being the largest survey of trans people ever conducted in Canada, is made available online, as a paper-and-pencil survey, or through a telephone interview.

[77] The RDS process was seeded with 16 primary respondents (members of the project's community engagement team) to initiate recruitment.

forthcoming Phase III aims to conduct follow-up interviews in order to build a deeper understanding of health concerns.

Overall, the results of the full Trans PULSE Project promises to provide a more detailed understanding of the variety of lived experiences of trans Ontarians, and will contribute significantly to trans discourse. Specifically, the involvement of trans persons at every level of the project signifies a shift from previous research approaches dominated by cissexual privilege and a cisnormative approach to transsexuality.

Conclusion

The position of transsexual bodies within a society's gender system – as legitimate bodies, as marginalized but acknowledged bodies, or as unacknowledged bodies – impacts not only *those* bodies but *all* bodies caught within that system. Naomi Scheman writes,

> As our (modern Western) world is now, failure to conform to the norms of gender is socially stigmatizing to an unbearable extent: to be human just *is* to be male or female, a girl or boy, a man or a woman. Those who cannot be readily classified by everyone they encounter are not only subject to physically violent assaults, but, perhaps even more wounding, are taken to be impossible to relate to humanly, as though one cannot use the pronoun "you" with anyone to whom one cannot with total assurance apply either "she" or "he". Those who are not stably, unambiguously one or the other are, as Susan Stryker puts it (1994, 240), "monsters" (Scheman 68, emphasis in original).

Such assumptions contribute to the organization of our social world. There exists an embodied privilege for those individuals who are considered "normal" within the system. Such persons are seen as legitimate through the erasure or denial of legitimacy accorded to trans people (alongside various "others" in the social realm). This erasure is also sustained by the assumptions of cissexual policy makers and service providers both

within legal and medical realms. Court rulings, official documents such as the Ontario *Vital Statistics Act* (1990), and the GID diagnosis all contribute to the discursive formation of transsexuality. The circulation of such expert knowledge through the legalization and medicalization of trans identities conveys truth about transsexuality and trans experiences at this particular historical moment. Such discourses both allow and limit what can be said about transsexuality in Canadian culture.

In this chapter, I examined the current structuring of medico-legal apparatuses and their reliance on cisnormative patterns of knowledge production that function to invalidate – or at times authenticate – gender experiences and identities. As well, I considered the significant work being undertaken by the Trans PULSE Project. In the following chapter, I expand on the argument presented here using a discourse analysis of major Canadian newspapers. My examination of news texts aims to uncover the ways in which official legal and medical discourses explored in this chapter – including the GID diagnosis – appear in the service of authenticating or invalidating identities and experiences that fall outside of cisnormativity.

The aim of my analysis is not to present the *definitive* discursive approach to transsexuality, but to present and analyze the dominant discourse of major Canadian newspapers. In order to achieve this, I will employ a qualitative discourse analysis to examine articles from the *National Post*, *The Globe and Mail*, *The Toronto Star*, and *Toronto Sun*.[78] This type of analysis, John Muncie explains, is the "detailed exploration of political, personal, media or academic 'talk' and 'writing' about a subject, designed to reveal how knowledges are organized, carried and reproduced in particular ways and

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[78] Due to linguistic limitations, only English languages sources will be examined. The above newspapers were selected because of their national reach.

through particular institutional practices" (74). I maintain that such media texts function as important sites that both reflect upon and contribute to the discourse regarding trans issues.

3. News Text Coverage of the Delisting and Relisting of SRS

The nature of reflective thought can be defined as "active, persistent, and careful consideration of any belief or supposed form of knowledge in the light of the grounds that support it and the further conclusion to which it tends" – John Dewey 9

In my previous chapter, I claimed that a medical diagnosis of Gender Identity Disorder (GID) – though problematic – is essential to a legal understanding of transsexuality in Ontario. Trans Ontarians must subject themselves to a medical model in order to gain access to legal recognition of their affirmed gender and sex. A diagnosis of GID, and approval for surgery from the Gender Identity Clinic at the Centre for Addiction and Mental Health (CAMH), provides a small number of trans Ontarians with access to public funding for sex reassignment surgery. Under Ontario's *Vital Statistics Act* (R.S.O. 1990, c. V. 4, s. 36), certification by two medical practitioners testifying to the results of the surgery is required as proof in requests for alterations to sex designations on government documents. Medical and legal discourses – as systems of expert knowledge[79] – are, then, significant frameworks through which the Canadian approach to transsexuality is mediated. Such expert systems also function, in part, to validate each other. This chapter builds on this argument by exploring the integration of such knowledge systems with news media texts.

My approach in this chapter is twofold. In the first section, I begin with a brief overview of Canadian health care and the Ontario Health Insurance Policy (OHIP). I proceed to outline the delisting – the ceasing of public funding – for sex reassignment surgery (SRS) in 1998, the key challenge to this ruling in *Hogan v. Ontario* (2006), and the relisting of SRS in 2008. In the second section of this chapter, I outline the

[79] We come to rely on expert knowledge producers as the definers of truth about a given topic within a discourse.

methodology used for the investigation and focus on my analysis of *The Globe and Mail*, *The Toronto Star*, *National Post*, and *Toronto Sun*.[80]

Finally, both sections are brought together through the analysis of the findings. Following the argument that news media shape and define truth, a total of 77 articles were analyzed along two dimensions. First, articles were analyzed based on the attitude or emotional content, what I have termed their 'tone'. Second, articles were analyzed based on the recurrence of key phrases and provocative word choices, what I call a "language" dimension. In general, I found that the news texts revolve around three major events: the delisting of sex reassignment surgery, coverage of the key human rights complaint and the Ontario Human Rights Tribunal's ruling in *Hogan v. Ontario*, and the relisting of sex reassignment surgery. I found that hard news texts remained the most neutral in tone – keeping in line with the narrative of journalistic neutrality – while opinion columns and letters to the editor varied in their tone between positive support for sex reassignment surgery and negative misunderstanding of the requirement of or the desire for surgery by trans subjects. Negative columns and letters to the editor overwhelmingly positioned sex reassignment surgery against other services, particularly those delisted during the research time frame (1998-2008), such as physiotherapy, care for autistic children and eye exams. Such bifurcation remained congruent with the Ministry of Health and Long Term Care's (Ministry) claim that the removal of public funding for sex reassignment surgery was not a politically motivated decision, but a

[80] Although the *Toronto Sun* is regarded as a daily tabloid newspaper, I have chosen to incorporate it into the data set for two reasons. First, while the *Toronto Sun* is a Toronto-city publication it maintains mass circulation and is available across the province of Ontario. The paper's high circulation numbers is significant in its reach to Ontarians. And second, as a result of its availability and distribution, I feel that it is important to examine its contribution to the discourse of transsexuality. The *Toronto Sun*'s coverage of trans issues continues to exert influence over its readers and affects other news publishers and online columnists and forums responding to its coverage.

reflection of the Ministry's commitment to the re-allocation of funds to "life-and-death" priorities like cardiac and cancer care. Ministry officials and medical personnel were mostly called upon to lend authority to surgery as a legitimate action. In certain instances, the texts called upon medical personnel to provide counter arguments for the removal of public support for surgery. I explore the use of this tactic in my discussion of four columns by Margaret Wente from *The Globe and Mail*. In summary, the news texts under examination reflect the troubled nature of the representation of transsexuality and sex reassignment surgery. The news texts are permeated by cisnormative assumptions about the relationship between sex and gender and the role of surgery in addressing feelings of incongruence felt by transsexuals. As a form of discourse analysis, this project then sheds light on the muddled discourse of transsexuality and sex reassignment surgery in Canada.

Background on Canadian Health Care, and SRS Delisting

As outlined in Section VI (Distribution of Legislative Powers) of *the Constitution Acts* (1867 to 1982), the "Establishment, Maintenance, and Management of Hospitals, Asylums, Charities, and Eleemosynary Institutions in and for the Province, other than Marine Hospitals" are the exclusive powers of provincial legislatures (*The Constitution Acts*, 1867 to 1982, Subsection 92(7)). In the place of a single national plan, Canada's publicly funded health care system – known as medicare – functions as a set of 'interlocking' provincial and territorial health insurance plans. This interlocking system is framed by the federal legislation for publically funded health care insurance known as the *Canada Health Act* (CHA). The primary objective of the Canadian health care policy as outlined by the CHA is "to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without

financial or other barriers" (*Canada Health Act*, R.S.C. 1985, c. C-6 [CHA]). The CHA requires all Canadian provinces and territories to publically fund "medically necessary" hospital services and "medically required" physician services[81] (Flood and Erdman 2). The CHA works to ensure that all "eligible residents of Canada have reasonable access to insured health services on a prepaid basis, without direct charges at the point of service for such services" (*Canada Health Act*, R.S.C. 1985, c. C-6 [CHA]). The provinces and territories must meet the established criteria and conditions established by the CHA in order to receive the full federal cash contribution under the Canada Health Transfer (CHT) payment programme (*Canada Health Act*, R.S.C. 1985, c. C-6 [CHA]).[82] The federal government is, therefore, responsible for setting and administrating the national standards for health care and in assisting in the financing for provincial care services through fiscal transfers. The federal government is also responsible for fulfilling other health-related functions such as disease prevention and health promotion, and the delivery of direct health care to specific groups such as veterans, First Nations People living on reserves, inmates of federal penitentiaries, the Royal Canadian Mounted Police and military personnel. The roles and responsibilities of Canada's health care system are shared between the federal and provincial-territorial governments. However, the latter are responsible for the management, organization and delivery of health services to the general public (Health Canada n. p.).

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[81] The Act defines "physician services" as any medically required services rendered by medical practitioners. However, the CHA does not contain a definition of "medical necessity," therefore, it is left to the discretion of the provinces to establish a definition. As Baker and Bhabha note: "Disputes about medical necessity can arise when services that had previously been listed are de-listed, whether based on 'evidence-based' analysis, physician-government negotiations designed to respond of financial constraints or the political viewpoint of the government of the day" (25).

[82] The CHT is the largest major transfer from the federal government to the provinces and territories. It provides "long-term predictable funding for health care, and supports the principles of the Canada Health Act which are: universality; comprehensiveness; portability; accessibility; and, public administration" (Department of Finance Canada n. p.).

The Ontario Ministry of Health and Long Term Care (Ministry) is responsible for all public sector provided health care funding, and for publishing a "Schedule of Benefits–Physician Services" (SOB-PS), which regulates the fee schedule for physicians' services, thereby indicating the benefits that are insured under the Ontario Health Insurance Policy (OHIP).[83] The SOB-PS lists information regarding some 4,800 insured physician services, including any applicable conditions or restrictions (Flood and Erdman 4). What health care services are publically funded by the province is ultimately determined through a variety of decision-making layers.

> The Ontario Ministry of Health and Long Term Care (Ministry) has historically consulted and negotiated with the Ontario Medical Association (OMA)[84], representatives of the medical profession in Ontario, regarding the 'tariffs' or fees paid to physicians for the provision of publicly-funded services. It is this process that indirectly determines what services are deemed 'medically necessary' and thus publicly funded (Flood and Erdman 2).

The OMA functions as the bargaining agent for Ontario physicians (Agreement between OMA and Ontario Minister of Health and Long-Term Care). Prior to 1995, the OMA and the government negotiated through "Framework Agreements". In 1995, newly elected Ontario Progressive Conservative Party expressed concern with increases in the rate of medical service utilization, and concluded that this increase was driven by physician behaviour. In 1996, the government passed Bill 26, the Savings and Restructuring Act, allowing the government to bypass the OMA to negotiate with physician groups either on "a specialty-specific or interest basis" (Flood and Erdman 3). This decision created instability when the Ministry failed to respond effectively or quickly enough, with the

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[83] The current SOB-PS available is provided at: http://www.health.gov.on.ca/english/providers/program/ohip/sob/sob_mn.html

[84] The Ontario Medical Association (OMA) represents the province's medical profession and membership is available to practicing physicians, residents, and students enrolled in Ontario faculties of medicine.

newly established groups threatening reduced services. In 1997, the government negotiated a new four-year agreement with the OMA in order to avoid further threats. The 1997 Agreement also established the Physician Services Review Committee (PSC). Membership in the PSC is restricted to representative members of the OMA and representatives of the Ministry. The PSC in Ontario functions both as a medium for labour relations between the government and the medical profession – in determining which physician services are publically funded and in deciding what services are de-listed or no longer eligible for public funding under OHIP (Flood and Erdman 3). The PSC relies on a variety of subcommittees in reviewing services. Under both the 1997 Agreement and the 2000 Agreement, the Ministry and the OMA agreed to create annual savings of (at least) $50 million dollars in the existing SOB-PS (Flood and Erdman 5).[85] However, while the PSC reviews and recommends potential changes to the SOB-PS, it is Cabinet that makes the final decision regarding which services to delist (Polansky 23).

On August 26, 1998, the Cabinet of the Government of Ontario proceeded to remove sex reassignment surgery from the SOB-PS without consultation with the PSC (*Hogan v. Ontario*, 2006 HRTO, 32). On December 24, 1998, the Ontario government sent out OHIP Bulletin #4330, outlining the changes to the regulations regarding SRS, effective as of October 1, 1998 (OHIP Bulletin #4330). Ontario patients who had completed the Gender Identity Clinic at the Centre for Addiction and Mental Health (CAMH) and who had been "recommended for surgery by the Clinic prior to October 1,

[85] The Physician Services Framework Agreement governs the relationship between the OMA and the Ministry (2004-2008 Physician Services Framework Agreement, OMA and the OMHLTC). The most recent Agreement is dated 2008.

1998" were still eligible for out-of-country approval (OHIP Bulletin #4330).[86] This decision marked the first time since the 1970s[87] that the Ontario government removed public funding for SRS for individuals who completed – and were subsequently recommended for surgery by – the Gender Identity Clinic program at the CAMH [formerly the Clarke Institute of Psychiatry] (Ontario Human Rights Commission 1999). Between 1980 and September 1998, the Gender Identity Clinic at the Clarke/CAMH recommended an average of seven to eight surgeries per year at a combined cost of $122,000 annually (Polansky 1). They only recommended for surgery those transsexuals suffering from profound GID.

Two components for the identification of GID are outlined in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR). First, there must be evidence of strong and persistent cross-gender identification, with the desire to be or the insistence that one is of the 'other sex'. Second, this cross-gender identification must be more than any desire for perceived cultural advantages of being the other sex. As well, in order for a GID diagnosis to be made, there must be evidence of persistent discomfort about one's assigned sex or a sense of inappropriateness in the gender role of that sex (DSM-IV-TR). Similarly, the World Health Organization's International Classification of Disease (ICD-10) classifies

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86 There are no hospitals in Ontario that perform SRS. Patients from Ontario are generally sent to The Centre Metropolitain de Chirugie Plastique in Montréal, Québec. Under special circumstances, OHIP may fund procedures received out of country. Refer to footnote 91 for an expansion on this point. Patients that are able to fund their own surgery and are not reliant on public-sector approval, can access procedures at the Menard Clinic in Montréal. The Menard clinic is the only private clinic in Canada specializing in sex reassignment surgery.

87 In 1978, the Ministry started to provide financing to the Clarke Institute (now known as CAMH), and added SRS to the SOB-PS (Polansky 26). Some news sources indicate 1969 as the year Ontario coverage of SRS begun while others list the year as 1970 or 1971 (Ferguson); (Egale Canada, 2004).

transsexualism as a mental or behavioural disorder. The ICD-10 defines transsexualism as

> A desire to live and be accepted as a member of the opposite sex, usually accompanied by a sense of discomfort with, or inappropriateness of, one's anatomic sex, and a wish to have surgery and hormonal treatment to make one's body as congruent as possible with one's preferred sex (ICD-10, ch. 5, F-64).

The Gender Identity Clinic at CAMH recommends patients to surgery as a last resort. The Clinic makes use of the criteria for sex reassignment surgery outlined in the World Professional Association for Transgender Health (WPATH), *Standards of Care* (2001),[88] which includes and affirms the diagnostic category of GID provided by the DSM and the category of Transsexualism by the ICD-10 (Centre for Addiction and Mental Health, n. p.).

The deleterious effect of the Cabinet decision to delist SRS was that some patients who had already started the transition process at the Gender Identity Clinic at CAMH prior to the delisting were, in effect, stranded mid-transition if they were unable to personally supplement their upcoming surgical fees. This led to several human rights complains to be lodged with the Ontario Human Rights Commission, including those by filed by Michelle Hogan, Martine Stonehouse, AB[89] and Andy McDonald.[90] On December 16, 2002, the Human Rights Tribunal of Ontario received the referral of the

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[88] The WPATH was formerly known as the Harry Benjamin International Gender Dysphoria Association. (The Harry Benjamin International Gender Dysphoria Association's Standards of Care for Gender Identity Disorders, Sixth Edition, February 2001). The WPATH maintains that sex reassignment surgery is proven to be beneficial for individuals with gender identity disorder (WPATH 2009, n. p.).

[89] Complainant is identified as A. B. only.

[90] In April 1999, Josef, a Canadian musician and MtF transgender activist, initiated a Charter Application to challenge the delisting of sex reassignment surgery as discriminatory against trans individuals. Josef's lawyer, Cynthia Petersen, put forth the arguments that the Charter protects trans people from discrimination based on gender identity and that the delisting violates the equality rights of transsexuals (Egale Canada 2004). The lawsuit claims that the decision to delist the procedure "runs counter to the rights of all citizens to obtain medically necessary treatment under the Canada Health Act" (Daly).

four complainants from the Ontario Human Rights Commission and requested that the cases be combined (*Hogan v. Ontario (Ministry of Health and Long-Term Care) (No. 3)* [2005], (CHRR Doc. 05-702, 2005 HRTO 49). The Ontario Human Rights Tribunal released an interim ruling on November 9 2005, with a Final Order released on November 28, 2006. The four complainants argued before the three-member panel of the Tribunal that the government's decision "amounted to discrimination with respect to services because of sex and/or disability" (Ontario Human Rights Commission 2007). Michelle Hogan, Martine Stonehouse, and AB had begun participating in the Gender Identity Clinic at CAMH the same time the regulation changes were taking place. The Tribunal dismissed the fourth complainant, Andy McDonald, as the complainant had not started the CAMH GIC program by October 1, 1998. *Hogan vs. Ontario* (2006 HRTO, 32) notes that the Cabinet included the following 'grandparent' clause [24(1) (3)] in their delisting announcement:

> SRS and any supporting services for such surgery would be insured services only if performed on a person who, *as of October 1, 1998, had completed* the Centre for Addiction and Mental Health in Toronto ('CAMH') Gender Identity Disorder ('GID') Clinic Program '*operated by*' that Clinic, and had been recommended for surgery by that Clinic, upon completion of the programme (*Hogan v. Ontario*, 2006 HRTO, 32, emphasis in original).

However, the majority of the Ontario Human Rights Tribunal (OHRT) ruling in *Hogan vs. Ontario* (2006 HRTO, 32) concluded that the grandparenting clause was inadequate, even if the delisting of sex reassignment surgery itself was not discriminatory, per se, against transsexuals (Polansky 2). The Tribunal noted that the decision to cut funding for sex reassignment surgery was discriminatory on the grounds of disability and sex against patients who had started medically supervised transitions before October 1, 1998.

The Final Order upheld the Interim Order and Decision. The Ontario government was ordered to fund only the surgeries of the three complainants as the guidelines prior to the delisting on October 1, 1998 outlined. The decision states, in part:

> 2. Ontario is to cease this contravention of the *Code* and refrain from committing the same or similar contravention.
> 3. When considering requests for funding for sex reassignment surgery, Ontario must apply the applicable parts of Regulation 552 and the SOB-PS as they stood immediately prior to October 1, 1998, for persons diagnosed with GID who have completed the program run by the Gender Identity Clinic at CAMH and who have been recommended by it for sex reassignment surgery (*Hogan v. Ontario* (Health and Long-Term care), 2006 HRTO 32 (CanLII), 164).

Although not a direct result of the OHRT Final Order, in 2008, Liberal Ontario Health Minister George Smitherman confirmed the re-listing of sex reassignment surgery as an insured benefit under the Ontario Health Insurance Policy. The Ministry of Health and Long-Term Care distributed OHIP Bulletin #4480, dated June 20, 2008. The bulletin notes the amendment of the Health Insurance Act, effective June 3, 2008, to include sex reassignment surgery as an insured service under OHIP. The following surgical procedures were listed as insured services under OHIP for approved sex reassignment surgery: Vaginoplasty in MtF (the removal of male genitals, construction of vagina, labia and clitoris); in FtM, Mastectomy (removal of breasts and chest reconstruction), option between Metoidioplasty ("freeing of the clitoris and construction of testes") or phalloplasty ("removal of female genitals, construction of male genitals"), and Hysterectomy (removal of uterus and ovaries, upon recommendation from CAMH) (Sherbourne Health Centre). OHIP does not provide public funding for the following procedures: breast augmentation, electrolysis, neck or vocal cord surgery, facial surgeries (such as lip augmentation, jaw shortening, and rhinoplasty), hair transplants, and male

chest contouring (unless part of a mastectomy procedure) (Sherbourne Health Centre). Similarly, hormones are treated like other prescription medication, paid for by the patient, a company health insurance, or an assistant government program such as the Ontario Drug Benefit Program for those patients who qualify. Patients meeting eligibility requirements for surgical procedures are directed to The Centre Metropolitain de Chirurgie Plastique in Montréal, Québec, or may seek treatment option outside of Canada.[91] Smitherman has suggested that an expected average of 8 to 10 Ontarians per year will make use of the coverage after undergoing extensive psychological evaluation. He estimates the cost to be $200,000 yearly out of a health budget of $40.2 billion (Ferguson). It is unclear whether these estimates take into consideration the ten-year backup of patients awaiting sex reassignment surgery.

To review, transsexuals are required to submit themselves to a medical diagnosis in order to access public funding for sex reassignment surgery and to have the government legally recognize their affirmed sex and gender. Therefore, the Cabinet's decision to delist sex reassignment surgery from the SOB-PS is situated in an environment of cissexual privilege, wherein Ministry and medical experts act as gatekeepers. The delisting of SRS acts as a restricting mechanism for low or middle-income trans individuals who wish to access surgery, and denies them the path towards legal recognition. The delisting decision enacted material influence over everyday lived experiences of trans persons including, but not limited to, searches by the police, medical coverage, employment security, emergency and long-term care, and housing or shelter

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[91] Only under exceptional circumstances will OHIP cover the cost of Out of Country services. This change in procedures occurs only where the service is insured under OHIP but not available within Ontario, or "delay in accessing services would result in medically significant irreversible tissue damage or death" (Sherbourne Health Centre).

access. As part of my research intention, I set out to find if this environment of cissexual privilege is also reflected in news media texts.

Discourse and Data

In order to uncover how identities that fall outside of cisnormativity are positioned in news texts, I employ a Foucauldian discourse analysis in my examination of the data set gathered from the *National Post*, *The Globe and Mail*, *The Toronto Star*, and the *Toronto Sun*. I chose these news producers for two reasons. As Bill Kovach and Tom Rosentiel note, news is "the material that people use to learn and think about the world beyond themselves" (38). Then, in accordance with a Foucauldian understanding of discourse, news media shape and define the types of knowledges that are understood as truths. I chose to examine newspapers as they have the capacity to feature longer stories and the potential for substantive coverage of issues, drawing on a variety of sources and re-presenting them to a broad audience. In this manner, news texts contribute to the production or constraining of particular knowledges. The four news producers I selected represent the major English Canadian news sources aimed at an Ontario urban audience. The four papers are also constituted as agenda setters[92] through their distribution power and influence over discussions and coverage of issues in other Ontario-based news mediums, including discussion forums such as blogs. According to the Newspaper

[92] Reese and Danielian (1991), and McCombs, Einsiedel and Weaver (1991) have illustrated that American news publications, such as *The New York Times* and *Time Magazine*, function as agenda setters for other American news publications. Although significant studies have not been conducted in relation to the agenda setting phenomena in Canada, the prevalence of articles appearing in smaller news publications, as well as materials posted online, that draw from the major Canadian dailies provides some room for the adoption of a similar use of agenda setting theory.

Audience Databank's 2009 study, these news sources have a combined weekly readership of 5,041,100.[93]

Second, the incorporation of the letter to the editor column – a unique feature of newspapers – provides an opportunity to examine the reader responses (though this claim must be nuanced by acknowledging that these texts are chosen and edited by each paper's editors). While I do not aim to deconstruct individual speech acts, I do take certain individual voices as significant to this analysis. In particular, I use as case studies four *Globe and Mail* columns by Margarete Wente and five letters to the editor responding to these columns. Wente's columns are significant because they allow us to observe a dialogue. The interaction occurring between columnist and reader responses published in the letter to the editor section allows for a variety of responses to be viewed back to back. Alongside Wente's texts, David Frum of the *National Post* and Christina Blizzard of the *Toronto Sun* remain the only columnists to write on trans related issues during the research time frame. Each of the columns express deeply personal opinions, and tend towards conservative points of view. Letters to the editor published in response to such columns by nature also express personal opinions, but range in their tone and discussion of transsexuality and sex reassignment surgery. The variety of opinions articulated within the columns and letters to the editor also produce and evoke the discourse of transsexuality and sex reassignment surgery in Canada.

I undertake this examination because discourses often reflect power relations. An analysis of how transsexual subject positions are situated and discussed reflects broader

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[93] The breakdown of the audience weekly readership of the four newspapers is as follows: *Toronto Star* 2,331,400; *The Toronto Sun* 1,078,200; *The Globe and Mail* 1,066,400, and *National Post* 565,100 (NADbank Study, n. p.).

assumptions about the relationship between sex and gender, and the role of expert knowledge systems as authoritative makers of truth.

Each of the news sources I examine call into being a different presumed audience, and function to produce knowledge that is disseminated to an Ontario urban audience. While there are differences that reflect each news producers' editorial stance and news values, this project is not so concerned with *what* these specific differences are or *how* they are managed. Rather, this project is concerned with the production of an Ontarian discourse regarding transsexuality and the OHIP coverage of sex reassignment surgery that uses expert knowledge systems.

Methodology

I incorporated documents produced over an 11-year period (1998-2008) into the dataset. Articles were obtained using a guided phrase search of the LexisNexis Academic database, a division of Reed Elsevier Inc., ProQuest LLC database, and the Canadian Business Current Affairs (CBCA) database, published by Micromedia, Inc. I pre-identified the following key phrases to be relevant to the search: trans, transgender, transsexual, sex reassignment surgery, sex change, gender surgery, gender switch, gender identity, gender identity disorder, and gender dysphoria. In all, I retrieved 283 articles through an exhaustive database search. In order to narrow the field, including reducing the number of duplicate articles and those produced by newswires intended only for journalists, I modified the search field by identifying and using the following key words: Canada, Ontario, OHIP, delisting/relisting, and CAMH/Clarke Institute. I excluded documents from the modified search if they mentioned SRS or transsexuality but were not concerned with it. For example, a significant number of such documents only list sex

reassignment surgery in a discussion of services delisted from the SOB-PS. I determined that such documents, though they employed one or more of the key phrases, were superficial in discussing the subject matter and were, therefore, removed from the sample.

I also excluded texts concerned with transsexuality or SRS that made references to three particular events: inmate Synthia Kavanagh's complaint against the Correctional Service of Canada, Sergeant Sylvia Durand's transition while employed by the Department of National Defence, and the case of Kimberly Nixon versus the Vancouver Rape Relief Society. Texts that reference or were concerned with federal regulations, such as those involving the Correctional Service of Canada, and the Department of National Defence and Canadian Forces were removed. In the case of the Correctional Service of Canada, inmate Synthia Kavanagh[94] filed a complaint with the Canadian Human Rights Commission based on her placement in a men's prison, restrictions on her hormone therapy and the denial of her requests for sex reassignment surgery. In 2001 Kavanagh won her case when the Federal Court of Canada ordered the Correctional Service of Canada to pay for her sex reassignment surgery and to remove her from a men's prison to a women's facility. The decision ruled that it is discriminatory for prisons to maintain a blanket prohibition on access to sex reassignment surgery and the Correctional Service of Canada was ordered to modify its Health Service Policy (*Kavanagh v. Attorney General of Canada* (2001)). In the case of the Department of National Defence and Canadian Forces, the Canadian military agreed to fund Sergeant Sylvia Durand's sex reassignment surgery. Durand was diagnosed with Gender Identity

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[94] Kavanagh was conditionally preapproved for SRS prior to her 1989 conviction for second-degree murder (*Kavanagh v. Attorney General of Canada* (2001)).

Disorder on January 20, 1998. She transitioned while serving, "with the full support of the Department of National Defense," becoming the first soldier in the world to do so (*Forrester v. Regional Municipality of Peel - Police Services Board* (2006) HR-0583/584-04 HRTO 13, at 126). Texts that predominantly reference these two cases are concerned with the federal government and, therefore, I deemed them inappropriate for the purposes of this project and its focus on the Ontario provincial health insurance coverage.

Similarly, I excluded texts primarily concerned with Kimberly Nixon and her interactions with the Vancouver Rape Relief Society. I arrived at this decision, in part, because the case began in British Columbia, and because the focus was not provincial funding for sex reassignment surgery. In the case of *Nixon v. Vancouver Rape Relief Society*, Nixon, a post-operative MtF transsexual, first filed a human rights complaint against Rape Relief in 1995, arguing that Vancouver Rape Relief had discriminated against her on the grounds of sex. Nixon had attempted to volunteer with the organization as a helper, but was turned away. Vancouver Rape Relief argued that Nixon did not meet the occupational requirements of the organization as she lacked life-long social experience as a woman.[95] The BC Human Rights Tribunal sided with Nixon, but two higher courts later agreed with Vancouver Rape Relief, overturning the original decision. In 2007, after various court decisions spanning almost 12 years, the Supreme Court of Canada refused to hear Nixon's appeal (*Nixon v. Vancouver Rape Relief Society* [2002] B.C.H.R.T.D. no. 1 (Q.L.); Perelle n. p.).

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[95] Vancouver Rape Relief's line of argumentation is in alignment with theorists who argue for life-long experience of being a woman. In Chapter One, I presented a similar argument put forth by Marcia Yudkin (1978). Similar to Vancouver Rape Relief, Yudkin finds the absence of an "uninterrupted past social identity as girls or women" to be problematic for a MtF transsexual's claim to a social identity as "woman" (104).

Overall, I incorporated a total of 77 texts into the dataset, with the following breakdown: 17 texts appear in *The Globe and Mail*; 22 texts appear in *The Toronto Star*; 25 texts appear in the *Toronto Sun*; and 13 texts appear in the *National Post*. Each text was numbered, divided by publishing source and arranged in order of publication date. Appendix B catalogues all of the articles analyzed in the study, and it suggests that coverage was sporadic over this period, often arising in response to particular events or in reference to developments in ongoing cases. I identified and categorized the section of the paper the text appears in – news, editorial, opinion column, feature, etc. – to code the visibility of the text and the authority with which it speaks. I present this information in Table 2 "Section and Tone". In my analysis of the texts, I approach hard news articles separately from those appearing in columns and letters to the editor sections. I explore the tone and variety of ways in which hard news articles approach transsexuality and sex reassignment surgery versus those in other sections of the newspaper.

Table 2. Section and Tone

News Source	Section	Tone
National Post	Column: 2 Editorial: 2 Feature: 1 Letters: 6 News: 1 Opinion: 1 Total Texts: 13	Negative: 7 Neutral[96]: 1 Positive: 5* *3 were positive towards TS but negative to articles they referenced
The Globe and Mail	Column: 4 Focus: 3 Letter to the Editor: 5 News: 4 Report on Business: 1	Negative: 4 Neutral: 9 Positive: 4*

[96] This neutrality is assumed – wherein the text attempts to convey information without prejudice. This is a facet of hard news writing. Many of these articles still make use of problematic phrases, or phrases with negative connotative meanings (such as "sex change"). Articles coded as neutral take into consideration the attempt at neutrality in conveying relevant information, even though I acknowledge that neutrality, as such, is a highly problematic notion.

	Total Text: 17	*1 Positive text, 3 Letter to Editors that were positive towards TS but negative towards article of reference
The Toronto Star	Letter: 5 News: 8 Life: 5 Other: 2 National Report: 1 Letter of Day: 1 Total Texts: 22	Negative: 2 Neutral: 14 Positive: 6
Toronto Sun	Cartoon: 1 News: 13 Comment: 1 Editorial-Opinion: 1 Letter of the Day: 2 Letter to the Editor: 7 Total Texts: 25	Negative: 10 Neutral: 13 Positive: 2* *1 Positive text that was negative towards article referenced

I also catalogued and documented all quoted or attributed sources within the texts. As well, I paid particular attention to locating the use of expert knowledge in the framing of each text. I noted references to legal cases, the DSM or the diagnostic category of Gender Identity Disorder, expert knowledge producers such as psychiatrists and academics, and the relation of trans identity or the 'trans movement' to gay identity and the LGBTQ movement. I have made this information available in Table 3 "Key References" for each news-producing source.

Table 3. Key References[97]

National Post	*DSM/APA: 6 *SRS in other provinces *Clarke/CAMH: 3 *Ministry personnel: 4 *CHA: 1 *Human Rights/Criminal Code: 1 *Transsexuality in relation to 'gays': 2 * SRS positioned against other services: 2	*Reference to Taxes: 3 *Ray Blanchard: 2 *Medical Personnel: 7 *WHO: 1 *MPs: 2 *OHRC: 2

[97] This column refers to the consultation of expert knowledge: the sources texts draw upon to claim authority.

The Globe and Mail	*GLQ Journal	*J. Michael Bailey: 2
	*Academics referenced: 17[98]	*Ray Blanchard: 2
	*Paul McHugh of John Hopkins: 3	*CHA: 2
	*GID: 4	*SRS in other provinces: 3
	*Charter: 2	*OMA: 1
	*Clarke-CAMH: 7	*WHO: 1
	*Medical Personnel: 5	*Ministry personnel: 2
	*Montréal Clinic: 3	*Kimberly Nixon: 3
	*OHRC-Code-Tribunal: 7	*Egale Canada: 1
	*Government ID: 1	*BC HRC: 1
	*Keith Norton: 1	*George Smitherman: 2
	*Harry (once quoted as "Henry") Benjamin: 2	
	*Cost and Number of Procedures Performed: 8	
The Toronto Star	*CHA: 5	*Clarke/CAMH: 9
	*OMA: 3	*Charter: 3
	*GIC: 5	*GID: 5
	*MPs: 6	*Medical personnel: 6
	*Ministry officials: 9	*Ray Blanchard: 3
	*WHO: 2	*APA/DSM: 2
	* Montréal Clinic: 2	*OHRC/Tribunal: 12
	*George Smitherman: 4	*Martine Stonehouse: 4
	*Michelle Josef/AB: 4	*Government ID: 3
	*Rainbow Health Networks: 2	
	*SRS positioned against other services: 3	
	*Cost and Number of Procedures: 14	
Toronto Sun	*Clarke-CAMH: 3	*Charter: 3
	*CHA: 1	*References to Taxes: 3
	*Michelle Josef: 4	*Elizabeth Witmer: 4
	*Human Rights: 2	*Ray Blanchard: 1
	*Keith Norton: 1	*Martine Stonehouse: 5
	*Health Insurance Act: 1	*OHR Tribunal: 6
	*George Smitherman: 6	*Marilyn Churley: 3
	*MPs: 6	*Egale Canada: 1
	*Stonehouse-Hogan-AB: 2	*OHRC: 5
	*OHRC Discussion paper: 2	* Montréal clinic: 2
	*SRS positioned against other service: 9	
	*Cost and Number of Procedures: 23	

I divided and analyzed the documents under examination along two dimensions: tone and language. I made use of the tone dimension to determine the attitude or

[98] Academics referenced are: Susan Stryker, C. Jacob Hale, Henry S. Rubin, Jay Prosser, Alice Dreger, Paul McHugh, J. Michael Bailey, Henry Benjamin, John Money, Olive Johnson, Diane Watson, and Ray Blanchard.

emotional content of the texts in question. Each article was coded as negative, neutral or positive in tone. I borrow the concept of "tone" from Tina Fetner who employs a bifurcated (and admittedly crude) measure of emotional expression present within her data set (417). The language dimension refers to the recurrence of key phrases and provocative words to describe situations, individuals and ideas. This bracket was also used to categorize the texts' overall approach to transsexuality and sex reassignment surgery and therefore contributes to the overall tone of the text. I coded the language dimension using two separate categories and this information is presented in Table 4 "Repeated Title Motifs," and Table 5 "Key Phrases".

Table 4: Repeated Title Motifs

National Post	*The Globe and Mail*	*The Toronto Star*	*Toronto Sun*
*Sex-Change *Medical need or a lifestyle? *Human Rights Issue *Misunderstood Transsexuals *Gender Dysphoria *Gender Confusion	*Sex Change Surgery *Mutilation is Not Therapy *Transsexuals as Political *Rights and Discrimination *Sex Reassignment - a Misdirection of Psychiatry?	* Free the Woman Within *Gender Gap *Slippery Slope *Sex-Change Operation *'Real-Life' Test * Delisting Prejudiced *Priorities all Wrong *Few Surgeries Approved *'Very Serious Medical Condition'	*Transsexual Surgery *Sex Change *Gender Switches *Sex OPs *Sex Swap *Gender Reassignment *Gender Surgery

Table 5: Key Phrases - Language used to frame the issue

National Post	*'Lifestyle' choice vs. psychiatric disorder. Meaningless to say it is a lifestyle choice if a psychiatric disorder *Cosmetic procedure *'Weird fetishware' associated with 'the Transgendered' *'Sickness of the mind' *Gender confusion syndrome

	* 'Nothing more than genital mutilation' *Pseudo 'sex-change' *GID is an artificial construct *'Mafia of transsexual academics' *GID serious medical condition *Gender essentialism: biology determines gender * SRS versus other delisted services * 'Pseudo-vagina' *Transphobia
The Globe and Mail	*Minorities * 'Chromosomes cannot be changed' *Autogynephilia *'Medically unnecessary treatment' *Gender dysphoria as psychiatric disorder *Netherlands survey: ratio of transsexual persons *Interviews with TS/TG *Physical descriptors of TS/TG subjects: clothing, makeup, hair, jewelry, secondary sex characteristics
The Toronto Star	*Psychiatric Disorder *Discrimination *Medically necessary treatment *'Lifestyle' operations *'Life-saving surgery' *'Matter of dollars and cents' *Conflation between GI and sexuality * SRS versus other delisted services *OHIP should pay only for 'vital' health-care treatment that 'benefit all of society'
Toronto Sun	*Not medically necessary *'Lifestyle operations' *Transsexuals 'lashing out' at the government *SRS versus 'priority programs' and 'life-and-death' care (cancer and cardiac care) *'We should not pit one illness against another' *'Open all women's washrooms to all men who think they're women' *Transsexuality and Gender Identity not about sex/or sexual orientation *'Sex-change operation is simply not in tune with the priorities of most people in Ontario' *'Freak' / plastic surgery *'Pay yourself' *'Liberals cave into demands'

Overview of Findings: Tone and Language

I found that "Sex Change" was the most frequent catch phrase under the language dimension. "Sex change" appears a total of 128 times within the texts, and was incorporated into 19 article titles. In comparison, "sex reassignment surgery" appears a total of 60 times within the texts, and was used in only 3 article titles.[99] I noted a shift in the appearance of SRS in the timeline: overwhelmingly, earlier texts rely on "sex change" in discussions of transsexuality and OHIP coverage, whereas texts dated closer to 2008 tend towards the use of SRS alongside "sex change," which remains in prominent use in article titles and in Letters to the Editor.

References to sex reassignment surgery as a "lifestyle choice," medically unnecessary or as "mutilation," also appear in each news producing source. In response to such claims, expert medical personnel appear to validate both those in favour of and those against public funding for sex reassignment surgery. Psychiatrists were quoted most often in favour of Gender Identity Disorder and sex reassignment surgery as a legitimate illness and as a medically needed procedure. In certain instances, medical personnel, such as Paul Fedoroff, and Paul McHugh of the Johns Hopkins University, were called upon to diminish the legitimacy of GID and sex reassignment surgery. Overall, I found that texts that diminished the medical necessity of sex reassignment surgery viewed the procedure as cosmetic or elective surgery.

Texts discussing the 1998 removal of sex reassignment surgery from the SOB-PS justify the government's unilateral delisting through a discussion of "reprioritizing health-care dollars" (Rapahel, *National Post,* 25 Nov 1998). Then Health Minister Elizabeth Witmer and members of the Ministry of Health were quoted in seven articles

[99] "Gender reassignment surgery" also appears a total of 19 times within the texts.

spanning all four news producers arguing the decision was not politically motivated while reaffirming the re-allocation of funds from sex reassignment surgery to cardiac care, cancer treatments and other "life-and-death priorities" (Lee-Shanok, *The Toronto Sun*, 20 June 1999). Tory MPP Marcel Beaubien is quoted in *The Toronto Star* acknowledging the limited cost-saving benefits of delisting sex reassignment surgery in comparison to cardiac care. However, he positions his argument in such a manner as to morally compel the reader to choose a father's heart transplant over a selfish desire for "sex change":

> 'It's a matter of dollars and cents. If your father needed a heart transplant but you wanted a sex change operation, which would you choose?' Beaubien admits the 'dollars and cents' in question did not add up to a lot of money. 'It was not a large amount of money, but $122,000 would do a bypass surgery,' he says (Volmers, *The Toronto Star*, 19 Jan. 2001).

This argument, however, does not take into consideration personal actions such as diet and exercise in contributing to the need for cardiac care or the post-operative costs of complications from bypass surgery. Overall, this positioning of sex reassignment surgery against other health services is problematic as it is reliant on an assumed ranking of priority. I return to this discussion of situating sex reassignment surgery against other OHIP services – including those delisted between 1998 and 2008 – in my discussion of letters to the editor. Before arriving at that analysis, however, I first begin with a discussion of hard news texts to highlight the differences between the texts based on the paper section they appear under.

News Texts

A total of 28 texts appear as hard news pieces within the dataset: 1 in the *National Post*, 4 in *The Globe and Mail*, 10 in *The Toronto Star*, and 13 in the *Toronto Sun*. These texts are distinguished from those appearing under other sections of the newspapers –

Life/Feature, Opinion Columns and Letters to the Editor – based on their tone and attempt at neutrality. Hard news texts function within the paradigm of objective journalistic writing, which aims to convey factual information without prejudice by only providing the facts of a given situation or event without commentary (Media Awareness Network n. p.). As Bill Kovach and Tom Rosentiel state, journalistic concerns with the concept of objectivity are present in the discipline of verification. "Practices such as seeking multiple witnesses to an event, disclosing as much as possible about sources, and asking many sides for comment are, in effect, the discipline of verification" (71). The news texts under examination overwhelmingly tend toward this approach by providing information for the reader, resulting in a tendency for the text's tone to appear neutral. This neutrality is assumed to a certain respect as many of the articles still make use of problematic phrases, or phrases with negative connotative meanings. Such problematic phrases include the reliance on using "sex change operations" in article titles and in the text. In my coding of articles as "neutral", I have taken into consideration the attempt at neutrality in conveying relevant information, even though I acknowledge that neutrality, as such, is a highly problematic notion. This hegemonic discourse finds parallels in the appearance of neutrality with the legal and medical discourses examined previously. The hard news texts' employment of an objective journalistic framework is similar in manner to the philosophical basis of orthodox modern science as a field in which objective knowledge of and about the world is attainable. In both instances, this objectivity is an ideal.[100]

[100] Ian Mitroff writes, "objectivity in science is due not to the fact that each individual scientist is objective (i.e., emotionally disinterested, impersonal in the testing of his (sic) and his fellow scientists' ideas), but rather, objectivity is due to the fact that scientists differ in the degree and kind of their subjective 'biases'" (B-615). Donna Haraway's 1998 article, 'Situated Knowledges: The Science Question in

The majority of the hard news texts cover the major developments related to the issue of public funding for sex reassignment surgery during the research time-frame. If we conceptualize the delisting and relisting of sex reassignment surgery under the SOB-PS as a story with particular developments, the hard news texts then act as signposts guiding the shifts in the tale. I found that three major events define the news texts' narratives. As Jeff Harder's 1998 *Toronto Sun* article 'Sex-change surgery gets axe' (pg 1) suggests, the story begins with the delisting announcement. The narrative proceeds with the Charter challenges and the human right complaints filed against the province (Gill, 'Ontario decision to halt sex-change surgery payment challenged.' *The Globe and Mail.* 4 May 1999. A10). The coverage of the human rights complaints, and the Ontario Human Rights Tribunal's interim ruling and final decision regarding *Hogan v. Ontario* presents the second major turn of events in the narrative of SRS coverage in Ontario. A 2005 article from *The Toronto Star* provides this summary: "[t]he Ontario government has been ordered to cover the costs of sexual reassignment surgery for three transsexuals left stranded when the previous Tory government delisted the service in 1998. ... The tribunal found that delisting the surgery had a disproportionate adverse impact on the complainants" ('Ontario must pay for sex-change surgery.' A14). Articles covering the lead up to the Tribunal's interim decision situate the discussion within a narrative of human rights, wherein Ontario's delisting is positioned against other provinces that (at the time) publicly funded SRS. The articles note the history of Ontario providing coverage for SRS prior to the delisting announcement in 1998, and make note of the internationally recognized nature of GID and SRS.

Feminism and the Privilege of Partial Perspective,' provides a critique of constructivist feminist deconstruction of scientific rhetoric and the concept of objectivity.

As exemplified by Alan Findlay's 21 April 2005 article, 'Sex swap near ok,' debates about the potential relisting of sex reassignment surgery appear alongside the Tribunal ruling within the narrative (*Toronto Sun*. pg 3). The 10 articles that cover the human rights challenges position the Ontario government's stance as willing to follow through with the ruling of the Tribunal, including reinstating full funding for sex reassignment surgery if the Tribunal had ruled that the delisting process was discriminatory. In 'Help eyed for sex changes', New Democrat MPP Marilyn Churley is quoted in dialogue with Premier Dalton McGuinty:

> 'If the tribunal rules in favour of reinstating funding, will you ensure that your government respects the ruling and reinstate(s) the funding immediately?' ... 'I want to be very, very direct to the member's question: Yes,' McGuinty said (*The Toronto Star*, 21 April 2005. A07).

As I discussed earlier, the Ontario Human Rights Tribunal's Final Order in *Hogan v. Ontario* (2006) only prescribed compensation for three of the complainants, and did not find the delisting itself discriminatory against transsexuals. Therefore, the McGuinty government was not compelled by obligation to reinstate public funding for SRS.

The final turn of events in the narrative concerns Health Minister George Smitherman's May 2008 announcement of the relisting of sex reassignment surgery under the SOB-PS. All four news producing sources cover the reinstatement of sex reassignment surgery, including the *National Post,* which had the lowest number of hard news texts dedicated to the issue (Huber. Ontario to resume funding for sex-change operations. *National Post*. 16 May 2008. A1). Overall, the news articles function to connect the different elements of a story – actors and actions, sources, background information and quotes – into a cohesive whole. For example, Palmer's *Toronto Star* article 'Sex-change delisting 'prejudiced'' (Palmer, 7 December 2002, A08) outlines the

Ontario Human Rights Commission's recommendation of four complaints to the Ontario Human Rights Tribunal [*Hogan v. Ontario*]. Similar to a significant number of other hard news articles, Palmer makes reference to the [6 to] 10 surgeries funded yearly by the province prior to delisting, which cost an annual average of about $120,000. The motif of referencing the average number of patients approved for surgery and the annual cost occurs in 18 of the 28 hard news texts. Palmer's article also provides background information on sex reassignment surgery, drawing on the expertise of Dr. Ray Blanchard from the Centre for Addiction and Mental Health, Susan Ursel, a human rights lawyer, and Maxine Petersen, a psychological associate from a private Montréal clinic specializing in SRS. In the text, Blanchard is paraphrased as stating,

> the sexology program [at CAMH] has always viewed surgery as a treatment of last resort for patients diagnosed with gender dysphoria, a clinical illness characterized by a desire to be, or insistence that one is, of the opposite sex. However, Petersen [states] that for some transsexuals, surgery is seen as the only option (Palmer, 7 December 2002, A08).

Here, the reliance on a medicalized model of transsexuality and the strong emphasis on the experts at CAMH and other medical institutions as gatekeepers of surgery are made explicit. In total, of the 28 hard news texts, 13 articles explicitly referenced the Clarke Institute of Psychiatry/Centre for Addiction and Mental Health, while 8 articles made direct references to Gender Identity Disorder or gender dysphoria. This reliance on expert knowledge producers is also reflected in the editorial columns and letters to the editor.

Opinion Columns and Letters to the Editor

Expert knowledge appears within opinion columns to both support public funding for sex reassignment surgery, and to argue against it. To discuss the use of expert knowledge in justifying a particular approach to transsexuality and sex reassignment

surgery, I take as a case study four columns by Margarete Wente[101] from *The Globe and Mail*, and five letters to the editor published in response to them. The Wente articles were published on 2 November 1999, 22 February 2000, 14 December 2000, and 25 August 2007. The letters to the editor in response to the columns appear within a week of the original article's publication. Each of Wente's four columns makes specific reference to a trans individual: Michelle Josef, Sylvia Durand, Kimberly Nixon, and Deborah Bershel. She does not reference any FtM transsexuals. Wente's texts make use of an essentialist framework wherein anatomical or chromosomal sex is understood as the 'real' definer of an individual's gender. In writing about Kimberly Nixon, Wente states: "To the untutored eye, she looks a bit like a man in a dress, which is not surprising in that she is equipped with a full set of XY chromosomes" (14 Dec 2000). Her texts make clear indications as to an individual's birth-assigned sex with specific references to the status of the individual's "penis".[102] Although Wente does use the correct or preferred gendered pronoun when she discusses specific individuals, she references original birth names – which are in contradiction to the gender appropriate name each individual has adopted – and gives detailed physical descriptors of each trans individual. She writes about Sylvia Durand: "She used to be named Sylvain. She's a 37-year-old sergeant in the Canadian army, a strapping six-footer with squared shoulders, spit curls, pearl-drop earrings, and chic maquillage, as they say in Québec" (Wente 22 Feb. 2000). Wente's texts make references to other physical descriptors, such as secondary sex characteristics and

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101 Wente is a conservative columnist with *The Globe and Mail*, and has similar counterparts in her tone and approach to transsexuality and sex reassignment surgery during the research time frame in the form of *National Post* columnist David Frum and *Toronto Sun* columnist Christina Blizzard.

102 Wente also conflates gender identity with sexual orientation, noting "transgendered people now share equal billing with gays, lesbians and bisexuals in the ever-expanding panoply of sexual minorities" (27 Aug 2007).

signifiers of gender for each trans subject: high cheekbones, slim hips, fluffy bangs, gold hoop earrings, owning dozens of pairs of high heels, dark skirts and teal tops, etc. Cissexual individuals, however, are not treated in the same manner. Rape Relief worker Suzanne Jay receives no physical descriptors, neither do Paul McHugh and an unnamed YMCA worker.

Most notably, Wente calls on elements of the medical system in order to lend legitimacy to her arguments. She uses medical classifications such as autogynephilia[103] and cites research undertaken at Johns Hopkins University, including references to psychiatrist Paul McHugh (who does not support sex reassignment surgery). Such tactics elevate the level of authority with which Wente speaks, as her arguments are supported with the use of expert knowledge in line with her views. Readers unfamiliar with such expert systems may be inclined to accept Wente's presentation of the issues without undertaking further examination. This acceptance is reflective of the tendency within news discourse wherein expert opinion is viewed as inherently valid, particularly when spoken in the name of scientific truth or from within the academy. This tendency is visible in Wente's use of academic/scientific experts and in the way perspectives from actual trans persons are diminished in relation to non-trans experts.

In a letter to the editor in response to Wente's Dec 14 2000 article (Who Gets To Be a Woman?), Kenneth J. Zucker, psychologist-in-chief at the Centre for Addiction and Mental Health, writes:

> Ms. Wente leans on Paul McHugh, psychiatrist-in-chief at Johns Hopkins University in Baltimore, a man with a sharp tongue, but little in the way of either clinical or academic credentials in the area of psychosexual development and its disorders. It is astonishing to me that Ms. Wente

[103] Ray Blanchard defines autogynephilia as "a man's paraphilic tendency to be sexually aroused by the thought or image of himself as a woman" (1989).

> knows nothing about the work of the gender-identity specialists at the Clarke Institute of Psychiatry (now the Centre for Addiction and Mental Health) who, for 30 years now, have made careful clinical and scientific contributions to the understanding and treatment of both children and adults with gender dysphoria, including empirical documentation of the efficacy of sex-reassignment surgery for adults (15 Dec 2000).

This letter to the editor is of particular interest as it highlights a rupture within the academy that may not always be advertised to outsiders. Even within the medical approach to sex reassignment surgery and transsexuality, there are a variety of factions: those against transsexuality as a legitimate subject position, those in favour of reparative therapy, and those who call for an end to the pathologization of non-cisnormative subject positions. This rupture is visible in responses from members of the academy to Wente's texts. Although Zucker is critical of Wente's work, Ray Blanchard, who works at CAMH alongside Zucker, refers to Wente's 2007 article as "otherwise excellent" (27 Aug 2007). Overall, of the five letters to the editor *The Globe and Mail* published in response to Wente's columns, two are from citizens without any specified qualifications, while three are from those in expert knowledge systems: Kenneth J. Zucker, Ray Blanchard and Alice Dreger.[104] Unlike letters to the editor of the other news producers, letters to the editor published in *The Globe and Mail* remain predominantly neutral or positive in tone, and exist within a framework of expert knowledge. This is reflective of the emphasis placed on the medicalized nature of transsexuality in Ontario, specifically in health and legal sectors. Below, I provide closer analysis of the letters to the editor appearing in the four news producing sources.

I found that letters to the editor that diminished the medical necessity of sex reassignment surgery often position public funding for the procedure(s) against other

[104] Alice Dreger is associate professor, clinical medical humanities and bioethics at Northwestern University.

delisted OHIP services – such as eye exams, physiotherapy and funding for parents of autistic children. Such texts were the most negative in tone, using inflammatory language and were at times fallacious in their arguments. The majority of such texts appear in the letter to editor columns:

> WELL, NOW I have heard it all! ("Sex swap OK near," April 21.) OHIP will no longer pay for my eye examination but they are considering paying for sex change operations. Hmmm … maybe I should give them a call to see if they can make me into a man with better vision (Marlo Martin, *Toronto Sun*, 22 April 2005).

> [S]ex changes, elective plastic surgery and the like have no criteria and justification for the allocation of public funds. It behooves each citizen to foot his own bill in case the need for non-medical, non-life-threatening remedies arise. The services of OHIP were introduced for genuine medical expenses and not to soothe thrill-seeking desires at the expense of maybe having to forgo otherwise needed assistance of higher priority (Herbet Misik, *Toronto Sun*, 4 July 1999, C2).

> I have worn glasses for 50 of my 55 years. I know that I need a new prescription. I cannot, however, afford the cost of the exam and new glasses for this legitimate and chronic medical condition. But it's nice to know that should I need gender reassignment surgery, I'm covered (Rob Cowan, *The Toronto Star*, 19 May 2008, AA07).

> Better the money be used for cancer research or something that would benefit all of society. If people decide they want to be another sex, they should pay for it themselves. This is not a health issue. Smoking, obesity, diet and other factors are. Nobody ever died as a direct result of not being the sex they want (William Mellor, *The Toronto Star*, 17 May 2008 AA05).

> Until OHIP agrees to pick up the tab[105] on obvious life-saving medicine, like my insulin, I cannot agree to tax dollars being spent on SRS (Elliot Skierszkan, *National Post*, 19 June 2008 A. 21).

Interestingly, *The Globe and Mail* was the only news source that did not contain letters to the editor that expressed such views, perhaps suggesting a different editorial stance aiming at more balanced reporting. However, as stated previously, Margaret Wente's

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[105] OHIP does not cover prescription medication. Each patient pays for prescription drugs.

columns are quite hostile towards trans persons. As well, conservative MP Pierre Poilievre is paraphrased in one article as stating, "[T]he province [should] pay only for 'vital' health-care treatments, and not sexual reassignment surgery" (20 May 2008). Five negative responses to such problematic sentiments and letters to the editor are also available in the dataset. For example, Geoffrey McLarney writes:

> Many readers seem intent on perpetuating the myth that sex reassignment surgery is a trivial, elective procedure. Many trans-individuals experience profound psychological distress if their incongruous bodies are not treated. For many, the alternative is suicide. Are there other procedures OHIP should be insuring? Of course. But to pit trans-Ontarians against autistic children or medical marijuana users is unfair and irrational (*The Toronto Star*, 20 May 2008, AA07).

As McLarney points out, positioning sex reassignment surgery against other medical services makes little sense. This bifurcation process functions to further create an Us/Them divide, wherein transsexuality and sex reassignment surgery are diminished and demonized in comparison to "worthy" and "life-saving" health care. In a cisnormative culture such as ours, those who attempt to live as the "opposite sex" often encounter ridicule, brutalization, degradation, attacks, or become the subjects of study or fetishization. The problematic components of the diagnostic category of Gender Identity Disorder aside, it remains that sex reassignment surgery is one venue through which a minority of trans Ontarians are able to live comfortably in society and acquire access to legal recognition.

Likewise, Ray Blanchard notes, the notion of transsexualism as a 'life-style choice' is absurd. "The 'choices' confronting transsexuals are whether to endure a lifetime of frustration and misery, kill themselves, or risk – and often lose – their families, friends, and jobs in the hopes of finding a happier life as the opposite sex"

(Blanchard and Fedoroff 4). The reality remains that sex reassignment surgery is offered as the *last* resort treatment to trans patients. Although the World Professional Association for Transgender Health, *Standards of Care* (2001) recommends that an individual considered for surgery live in the preferred gender for 12 months, the CAMH Gender Identity Clinic requirements call for a two year period of successful cross-living in the preferred gender before a patient is even considered eligible for sex reassignment surgery (Centre for Addiction and Mental Health). In alignment with the historical yearly number of seven or eight patients who were recommended for surgery prior to the 1998 delisting, and George Smitherman's estimated eight to ten since the relisting in 2008, we can note that access to surgery is not a casually granted procedure. The process of "changing sex" is a difficult one, and is a potential reality for only a handful of trans Ontarians. The Gender Identity Clinic at the Centre for Addiction and Mental Health is the Ministry mandated clinic for public sector funding for sex reassignment surgery in Ontario. Therefore, trans individuals who wish to access surgery supplemented by OHIP must submit to the regulations and criteria set out by CAMH, including relocations to Toronto were the clinic is located. This reflects the strong hold that CAMH has over publically funded sex reassignment surgery in Ontario. Letters to the editor that make light of the ease with which one can access public funding for sex reassignment surgery do not reflect the reality of the difficulty in accessing such funds.

Final Comments

In the same manner as the legal and medical fields I have examined, news texts function through discourse, which "brings about a process of categorization, of ordering and normalizing, which generates knowledge about ourselves, and about the events we

are living" (Martin-Rojo 51). Trans subjects are articulated on two axes in the news discourses: first, through a perceived sense of diminished capacity that requires expert medical knowledge to "call into being" the experience of gender dysphoria and to approve access to surgery; and, second, through the process of exclusion based on Us/Them binaries. Here, I draw upon Luisa Martin-Rojo's Foucauldian notion of exclusion,[106] and argue that trans subjects are excluded in Canadian newspapers through the processes of dividing, and rejecting. In the process of dividing, there is an Us/Them binary that is employed: the sane and normal "Us" (the cissexual[107]) are posited against the insane or abnormal "Them" (the transsexual). In the process of rejecting, a segregation or marginalization takes place wherein a negative image is produced of the trans subject as posited against the cohesive "Us" (Martin-Rojo 50). This process of dividing and rejecting is noticeable in news texts in the categorization of individuals into groups (as cissexuals or transsexuals), and through the positioning of sex reassignment surgery against other delisted services.

Discourses that speak of transsexuality and sex reassignment surgery as a "lifestyle choice" or as elective surgery diminish the lived experience of gender dysphoria in relation to cisnormativity. Arguments against public funding for SRS aim to delegitimize the reality of trans subjectivity and needed support; transsexuality and sex reassignment surgery become coded as mentally unstable, morally ambiguous and self-centered actions against other deserving ailments and persons. In comparison, the trans

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106 Although Martin-Rojo's work does not contend with trans subjects I find her theoretical frameworks to be transferable to my discussion here.

107 Though I continue to use the term 'cissexual' none of the articles employ this terminology to refer to non-trans individuals. I argue that this lack of critical awareness is due to existing power relations in Canadian society that perceive cissexuals as the norm, perpetuating the belief that 'norms' do not require examination or justification. Transsexuality, then, comes to be defined as abnormal only in relation to the perceived normality of cissexuality.

individuals and the allies who appear within the news texts strive to legitimize transsexuality and to provide "worthy" arguments for funding sex reassignment surgery.

Although the opinion columns and the letters to the editor are secondary to the hard news texts, together they all function to expose and re-produce primary narratives about transsexuality to the general Canadian population. As Vincent et al. indicate, "[T]he mass media are one of the most powerful institutional forces in society" (282) and "newspapers remain one of the most prevalent media forms" (283). The myth of news objectivity hides the fact that news texts – even those labeled here as hard news – are interpretations rather than reflections of affairs (Martin-Rojo 53). Each of the four papers under examination give – to varying degrees – the impression of being objective newspapers seeking truth. One method of increasing the appearance of truth in news is to make use of other reliable sources, such as authorities and professionals. Although trans subjects are referenced and quoted within the texts examined above, the general social hierarchy is reproduced through the reliance on medical opinions and legal cases, which reflect the knowledge systems in which transsexuality is officially discussed in Ontario. Therefore, as systems of hegemonic norms, the legal, medical and news discourses present a normative understanding of transsexuality – one where expert knowledge is required to substantiate a transsexual subject position.

Overall, the above news texts reveal the divided status of sex reassignment surgery and transsexuality in Ontario. Particularly, the positing of sex reassignment surgery against other delisted OHIP services serves to highlight the misunderstood nature of transsexuality. The Ontario Cabinet's decision to delist sex reassignment surgery without consultation of the OMA, members of CAMH or individuals from the affected

community requires further examination. Then Health Minister Elizabeth Witmer and members of the Ministry of Health and Long Term Care maintained that the 1998 delisting was part of cost-saving efforts in the aim of reprioritizing the SOB-PS and not a political move. Although the diagnosis of Gender Identity Disorder poses problems, it is the only venue for trans persons to have their affirmed sex/gender recognized by the province of Ontario. It remains that transsexuality and the procedures of sex reassignment surgery challenge deeply held beliefs about the relationship between sex and gender.

Afterword

The public opinion and lived experiences of trans people are affected by at least two distinct but interrelated epistemic discourses: legal frameworks and medical literature. At present, there is an opportunity to enact institutional change within each discourse. The first opportunity concerns the ongoing revisions to the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) and the diagnostic category of Gender Identity Disorder (GID) in preparation for the publishing of DSM-V. The second opportunity presents itself in NDP MP Bill Siksay's proposed Bill C-389, which aims to incorporate explicit protection for gender identity and gender expression in the Canadian Human Rights Act (CHRA) and the Criminal Code of Canada. Although these proposals are currently under examination and the ultimate outcome is unknown, I feel that they reflect the pressing need to work towards addressing the concerns of the trans community and the discourse of transsexuality.

In 1999, the process of revising the DSM began with leaders from the American Psychiatric Association (APA), the World Health Organization, and World Psychiatric Association involved in the research planning of specific diagnostic areas (APA 2010a, n. p.). In 2006, Dr. David J. Kupfer was announced as chair and Dr. Darrel A. Regier as vice chair of the task force to oversee the development of DSM-V. Additional members of the APA were nominated to the task force to review the literature and scientific advancements associated with the 13 work fields to develop draft diagnostic criteria for DSM-V. In July 2007, Kenneth J. Zucker (Psychologist-in-Chief at the Centre for Addiction and Mental Health) was elected as the chair of the DSM-V workgroup on Sexual and Gender Identity Disorders. The gender committee of the DSM – announced in

May 2008 – is composed of Drs. Jack Drescher, Heino F. L. Meyer-Bahlburg, and Friedemann Pfafflin and chaired by Dr. Peggy Cohen-Kettnis.[108] The first proposed draft criteria for changes to the GID diagnosis took two years to announce, and must still pass through a variety of tasks – including Phase I and II pilot testing, field trials and revisions – before it is adopted. The APA expects the final, approved DSM-V to be released in May 2013.

In Chapter 2, I outlined the complicated relationship of trans individuals and the pathologizing nature of the GID diagnostic criteria. Without advocating for a declassification or complete removal of GID unescorted by another system to be implemented in its place, I maintain that the upcoming revision to the DSM provides a concrete opportunity to address some of the most problematic grievances of the GID diagnosis. The medical community is faced with the opportunity to address and effect positive change in the discourse of transsexuality and gender variance. As the APA's website indicates, while continuity between the DSM-IV-TR and DSM-V is desirable, "there has been no pre-set limitation on the nature and degree of change that work groups can recommend for *DSM-V*" (APA 2010a, n. p.). This transitional time for the DSM allows the APA to announce, officially, that gender variance is not in and of itself a mental illness, and to remove the stigma associated with it. Gender incongruence or gender dysphoria only becomes a mental disorder when it causes the individual significant problems, much of which can be the result of prejudiced social practice and discriminatory institutions.

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[108] The DSM-V workgroup on Sexual and Gender Identity Disorders also includes Irving M. Binik, Ray Blanchard, Lori Brotto, Martin Kafka, Richard B. Jrueger, Niklas Langstrom, and Robert Taylor Segraves. The members of the workgroup come from the United States, Canada, The Netherlands, The United Kingdom, Sweden, and Germany.

However, as the first release of the DSM-V development proposed revisions indicate,[109] the APA has not embraced the opportunity to enact significant change. The gender work group's DSM-V proposal has widened the definition of *Gender Incongruence* (the new name replacing GID) to include intersex individuals, or those born with physical *Disorders of Sex Development* (DSD) (APA 2010b, n. p). As well, the DSM-IV-TR's Criterion D, which outlined distress and/or impairment in social, occupational or other areas of functioning, has been removed in the proposed DSM-V. The work group proposes that distress and/or impairment be evaluated separately and independently from the implementation of the GI diagnosis (APA 2010b, n. p). This proposed change is positive in that it no longer assumes adolescents and adults diagnosed with GID/GI function in an universally impaired manner. However, it remains unclear whether anyone with a non-traditional gender identity would receive a diagnosis of GID/GI if experiencing "A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months duration" even if they are functioning well and are happy (APA 2010b, n. p.). The proposed revisions remain in a state of flux as they continue to be tested in field trials, and may indeed undergo significant changes prior to the publishing of DSM-V in 2013. It remains to be seen how the APA and medical community respond to the various challenges posed to the DSM-IV diagnosis of GID in light of inherent versus social and institutional distress and disability.

As the Ontario Human Rights Commission has noted, "there are, arguably, few groups in society today who are as disadvantaged and disenfranchised as the transgendered community. Transphobia combined with the hostility of society to the very

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[109] Proposed Draft Revisions to DSM Disorders and Criteria are available online at the APA's DSM5 development website: http://www.dsm5.org/Pages/Default.aspx

existence of transgendered people are fundamental human rights issues" (2000, 2). Yet, neither gender identity nor gender expression is an enumerated ground in the Ontario Human Rights Code or the Canadian Human Rights Act. In Canada, The North West Territories is the only province or territory to explicitly recognize human rights protection for trans persons by including gender identity as prohibited grounds (Northwest Territories Human Rights Act S.N.W.T. 2002, c. 18).[110]

In June 2000, the Ontario Human Rights Commission released its *Policy on Discrimination and Harassment because of Gender Identity.* The Commission's Policy resulted from a discussion paper on the issue of gender identity published in October 1999, and states that complaints of discrimination or harassment based on gender identity are to be accepted by the commission under the grounds of sex and/or disability. However, implicit protections at the federal and provincial-territorial level for trans persons in the fields of sex, disability or sexual orientation, may not be applicable in all cases, are subject to interpretation, and, as such, remain inadequate. In light of this inadequacy, New Democratic Party MP Bill Siksay[111] (Burnaby-Douglas) introduced Bill C-389, titled An Act to Amend the Human Rights Act and the Criminal Code (Gender Identity and Gender Expression) during the 40th Parliament - 2nd Session (Jan. 26, 2009 - Dec. 30, 2009). The private members' bill addresses the lack of explicit federal protections for transgender and transsexual people in provisions of the Canadian Human Rights Act (CHRA) and the Criminal Code of Canada.

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110 The jurisdictions of Vancouver, Toronto and Ottawa have also adopted policies to protect transgender and transsexual people.

111 Siksay is the New Democrat critic for Gay, Lesbian, Bisexual, Transgender and Transsexual Issues. Siksay is also an activist with Affirm United, the organization of gay, lesbian, bisexual and transgender United Church members and adherents (NDP website n. p.).

Bill C-389 proposes to add gender identity and gender expression as prohibited grounds for discrimination to the Human Rights Act. Under the Criminal Code, gender identity and gender expression would also be added as distinguishing characteristics to be protected under subsection 318(4), Definition of 'identifiable group' (Canada, Bill C-389). Siksay has tabled this bill twice before; in the previous attempts, the bill died on the order paper due to Parliament being dissolved or being prorogued prior to the 2008 Canadian elections. In this third attempt, Bill C-389 achieved first reading in the House of Commons on May 15, 2009, during the 2nd session of the 40th parliament. In the 3rd session (March 3, 2010-), the bill was first read on March 3, 2010, placed on the Order of Precedence on April 15, 2010 with the first hour of debate completed on May 10, 2010[112]. A second hour of debate will occur when C-389 once again reaches the top of the order of precedence.

It is yet undetermined if the bill will receive Royal Assent and come into force. The passage of Bill C-389 through the House of Commons and the Senate would provide provinces and municipalities with guidelines for the implementation of criminal sanctions to address the pervasive prejudice, discrimination and violence faced by many trans people. The experience of discrimination and violence continues to be a large component within research conducted regarding the trans community. For example, Chris Boodram and Corie Langdon's Trans Legislative Needs Survey (2004) is concerned with violence, discrimination and harassment experienced by trans people in the Ottawa area. Although the sample population was limited, they found that safety and human rights issues were

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[112] The official report of the first hour of debate concerning Bill C-389 (see: Private Members' Business) is published under the authority of the Speaker of the House of Commons (Canada. Parliament. House of Commons Debates, May 10, 2010), and is made available online at: http://www2.parl.gc.ca/HousePublications/Publication.aspx?Pub=Hansard&Doc=43&Language=E&Mode=1&Parl=40&Ses=3

significant concerns of the Ottawa trans community. Their research found that trans participants experienced high incidences of verbal harassment (74%), intimidation (54%), hate propaganda (41%), attempted assault (38%) and physical assault without a weapon (32%) (n. p.).[113] Their findings echo other international studies concerned with trans communities. A 1992 study conducted in London, England found that 52% of MtF transsexuals and 43% of FtM transsexuals surveyed had been physically assaulted (145). Viviane K. Namaste's interviews (2000) – conducted in the summer of 1995 in Ontario – also highlight violence as central to her research participants, suggesting that taken for granted experiences such as basic safety remain a pressing issue for the survey's trans participants. Egale Canada's First National Climate Survey on Homophobia in Canadian Schools (2009) reported that 9 of 10 trans students were verbally harassed because of their gender expression. As well, the survey showed that 95% of trans students felt unsafe at school in comparison to the 20% of cissexual students who expressed similar feelings (Egale 2009, n. p.).

As the members of the House of Commons continue to debate Bill C-389, I would also like to recognize Canada's international support of human rights protection. Canada is a signatory, alongside 66 other countries, to the draft text of the United Nations Statement on Human Rights, Sexual Orientation and Gender Identity (2008). The draft statement reaffirms "the principle of non-discrimination which requires that human rights apply equally to every human being regardless of sexual orientation or gender identity" (UN General Assembly). The draft text condemns violence, harassment, discrimination,

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[113] Boodram and Langdon also note that participants experienced "significant levels of discrimination in housing, employment and services including unwelcome comments at work, 43%; unwelcome comments in living accommodations, 32%; and discrimination in bars, restaurants, schools, universities and colleges, each at 32%" (n. p.).

exclusion, stigmatization, and prejudice based on sexual orientation and gender identity, alongside its condemnation of torture, arbitrary arrest, killings and executions, and deprivation of economic, social, and cultural rights based on those grounds (UN General Assembly). If the government of Canada presents itself as a country that is internationally concerned with the human rights protections of all transgendered and transsexual individuals, it stands that the government should also implement equivalent federal policies at home. As Canadians we must aim for more than mere tolerance or accommodation of trans related issues, legal or otherwise. Trans Canadians deserve the same level of respect and dignity accorded to other Canadians.

Appendices

Appendix A: (Ontario) *Vital Statistics Act* R.S.O. 1990, CHAPTER V.4
Last amendment: 2009, c. 33, Sched. 17, s. 13.

Changes Resulting from Transsexual Surgery

Changing sex designation

36. (1) Where the anatomical sex structure of a person is changed to a sex other than that which appears on the registration of birth, the person may apply to the Registrar General to have the designation of sex on the registration of birth changed so that the designation will be consistent with the results of the transsexual surgery.

Application

(2) An application made under subsection (1) shall be accompanied by,

(a) a certificate signed by a medical practitioner legally qualified to practise medicine in the jurisdiction in which the transsexual surgery was performed upon the applicant, certifying that,

(i) he or she performed transsexual surgery on the applicant, and

(ii) as a result of the transsexual surgery, the designation of sex of the applicant should be changed on the registration of birth of the applicant;

(b) a certificate of a medical practitioner who did not perform the transsexual surgery but who is qualified and licensed to practise medicine in Canada certifying that,

(i) he or she has examined the applicant,

(ii) the results of the examination substantiate that transsexual surgery was performed upon the applicant, and

(iii) as a result of the transsexual surgery, the description of the sex of the applicant should be changed on the registration of birth of the applicant; and

(c) evidence satisfactory to the Registrar General as to the identity of the applicant.

Alternate medical evidence

(3) Where it is not possible to obtain the medical certificate referred to in clause

(2) (a) or (b), the applicant shall submit such medical evidence of the transsexual surgery as the Registrar General considers necessary.

Notation on birth registration to be consistent with result of surgery

(4) The Registrar General shall, upon application made to him or her in accordance with this section, cause a notation to be made on the birth registration of the applicant so that the registration is consistent with the results of the surgery.

Old certificates to be returned

(5) Any person in possession or control of a certificate or certified copy of a birth registration issued before the making of a notation under subsection (4) shall return the certificate or certified copy to the Registrar General forthwith upon demand.

Birth certificate issued after notation

(6) Every birth certificate issued after the making of a notation under this section shall be issued as if the original registration of birth had been made showing the designation of sex as changed under this section. R.S.O. 1990, c. V.4, s. 36.

Citation: *Vital Statistics Act* R.S.O. 1990, CHAPTER V.4. Government of Ontario. ServiceOntario e-Laws. Accessed 26 Jan 2010. http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90v04_e.htm

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